Volume 35, Number 3
Pages 157–346
February 1, 2010

SALUS POPULI SUPREMA LEX ESTO

"The welfare of the people shall be the supreme law."

ROBIN CARNAHAN

SECRETARY OF STATE

MISSOURI REGISTER

The *Missouri Register* is published semi-monthly by

Secretary of State

Robin Carnahan

Administrative Rules Division

James C. Kirkpatrick State Information Center

600 W. Main

Jefferson City, MO 65101

(573) 751-4015

ISSN 0149-2942, USPS 320-630; periodical postage paid at Jefferson City, MO

Subscription fee: $56.00 per year

POSTMASTER: Send change of address notices and undelivered copies to:

MISSOURI REGISTER
Office of the Secretary of State
Administrative Rules Division
PO Box 1767
Jefferson City, MO 65102

The *Missouri Register* and *Code of State Regulations* (CSR) are now available on the Internet. The Register address is http://www.sos.mo.gov/adrules/moreg/moreg.asp and the CSR is http://www.sos.mo.gov/adrules/csr/csr.asp. These websites contain rulemakings and regulations as they appear in the Registers and CSR. These websites do not contain the official copies of the Registers and CSR. The official copies remain the paper copies published by the Office of the Secretary of State pursuant to sections 536.015 and 536.031, RSMo Supp. 2009. While every attempt has been made to ensure accuracy and reliability, the Registers and CSR are presented, to the greatest extent practicable as they appear in the official publications. The Administrative Rules Division may be contacted by email at rules@sos.mo.gov.

The secretary of state's office makes every effort to provide program accessibility to all citizens without regard to disability. If you desire this publication in alternate form because of a disability, please contact the Division of Administrative Rules, PO Box 1767, Jefferson City, MO 65102, (573) 751-4015. Hearing impaired citizens should contact the director through Missouri relay, (800) 735-2966.

MISSOURI REGISTER

February 1, 2010 Vol. 35 No. 3 **Pages 157–346**

IN THIS ISSUE:

EMERGENCY RULES

Department of Higher Education
University of Missouri 161
Department of Social Services
MO HealthNet Division 161
Missouri Consolidated Health Care Plan
Health Care Plan 164

EXECUTIVE ORDERS 203

PROPOSED RULES

Department of Economic Development
Public Service Commission 207
Department of Elementary and Secondary Education
Division of School Improvement 210
Division of Career Education 214
Department of Natural Resources
Soil and Water Districts Commission 214
Department of Revenue
State Tax Commission 220
Elected Officials
State Auditor 224
Retirement Systems
The Public School Retirement System of Missouri 226
Missouri Consolidated Health Care Plan
Health Care Plan 229

ORDERS OF RULEMAKING

Department of Mental Health
Certification Standards 305
Department of Social Services
MO HealthNet Division 306
Retirement Systems
The County Employees' Retirement Fund 312
Department of Insurance, Financial Institutions and Professional Registration
Insurance Solvency and Company Regulation 312
Life, Annuities and Health 312
State Board of Pharmacy 313
Real Estate Appraisers 314

IN ADDITIONS

Department of Conservation
Conservation Commission 316
Department of Transportation
Missouri Highways and Transportation Commission 316
Department of Health and Senior Services
Missouri Health Facilities Review Committee 317
Department of Insurance, Financial Institutions and Professional Registration
Sovereign Immunity Limits 318

CONTRACTOR DEBARMENT LIST 319

DISSOLUTIONS 320

SOURCE GUIDES

RULE CHANGES SINCE UPDATE 325
EMERGENCY RULES IN EFFECT 334
EXECUTIVE ORDERS 336
REGISTER INDEX 338

Register Filing Deadlines	Register Publication Date	Code Publication Date	Code Effective Date
October 1, 2009	**November 2, 2009**	November 30, 2009	December 30, 2009
October 15, 2009	**November 16, 2009**	November 30, 2009	December 30, 2009
November 2, 2009	**December 1, 2009**	December 31, 2009	January 30, 2010
November 16, 2009	**December 15, 2009**	December 31, 2009	January 30, 2010
December 1, 2009	**January 4, 2010**	January 29, 2010	February 28, 2010
December 15, 2009	**January 15, 2010**	January 29, 2010	February 28, 2010
January 4, 2010	**February 1, 2010**	February 28, 2010	March 30, 2010
January 15, 2010	**February 16, 2010**	February 28, 2010	March 30, 2010
February 1, 2010	**March 1, 2010**	March 31, 2010	April 30, 2010
February 16, 2010	**March 15, 2010**	March 31, 2010	April 30, 2010
March 1, 2010	**April 1, 2010**	April 30, 2010	May 30, 2010
March 15, 2010	**April 15, 2010**	April 30, 2010	May 30, 2010
April 1, 2010	**May 3, 2010**	May 31, 2010	June 30, 2010
April 15, 2010	**May 17, 2010**	May 31, 2010	June 30, 2010
May 3, 2010	**June 1, 2010**	June 30, 2010	July 30, 2010
May 17, 2010	**June 15, 2010**	June 30, 2010	July 30, 2010
June 1, 2010	**July 1, 2010**	July 31, 2010	August 30, 2010
June 15, 2010	**July 15, 2010**	July 31, 2010	August 30, 2010

Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at http://www.sos.mo.gov/adrules/pubsched.asp

Missouri Participating Libraries

The *Missouri Register* and the *Code of State Regulations*, as required by the Missouri Documents Law (section 181.100, RSMo Supp. 2009), are available in the listed participating libraries, as selected by the Missouri State Library:

Jefferson County Library
PO Box 1486, 3021 High Ridge
High Ridge, MO 63049-1486
(314) 677-8689

Jefferson College Library
1000 Viking Drive
Hillsboro, MO 63050-2441
(314) 789-3951 ext. 160

St. Louis Public Library
1301 Olive St.
St. Louis, MO 63103-2389
(314) 539-0376

St. Louis University Law Library
3700 Lindell Blvd.
St. Louis, MO 63108-3478
(314) 977-2742

Eden/Webster Library
Eden Theological Seminary/
Webster University
475 East Lockwood Ave.
St. Louis, MO 63119-3192
(314) 961-2660 ext. 7812

Thomas Jefferson Library
University of Missouri-St. Louis
8001 Natural Bridge Road
St. Louis, MO 63121-4499
(314) 516-5084

Washington University Law Library
Washington University
Campus Box 1171, Mudd Bldg.,
One Brookings Dr.
St. Louis, MO 63130-4899
(314) 935-6443

St. Louis County Library
1640 S. Lindbergh Blvd.
St. Louis, MO 63131-3598
(314) 994-3300 ext. 247

Library
Maryville University
13550 Conway Road
St. Louis, MO 63141-7232
(314) 529-9494

Pickler Memorial Library
Truman State University
100 E. Normal
Kirksville, MO 63501-4221
(660) 785-7416

Learning Resources Center
Mineral Area College
PO Box 1000
Park Hills, MO 63601-1000
(573) 431-4593

Cape Girardeau Public Library
711 N. Clark
Cape Girardeau, MO 63701-4400
(573) 334-5279

Kent Library
Southeast Missouri State University
One University Plaza
Cape Girardeau, MO 63701-4799
(573) 651-2757

Riverside Regional Library
PO Box 389, 204 South Union St.
Jackson, MO 63755-0389
(573) 243-8141

Rutland Library
Three Rivers Community College
2080 Three Rivers Blvd.
Poplar Bluff, MO 63901-2393
(573) 840-9656

James C. Kirkpatrick Library
University of Central Missouri
142 Edwards Library
Warrensburg, MO 64093-5020
(660) 543-4149

Kansas City Public Library
14 West 10th Street
Kansas City, MO 64105
(816) 701-3546

Law Library
University of Missouri-Kansas City
5100 Rockhill Road
Kansas City, MO 64110-2499
(816) 235-2438

Miller Nichols Library
University of Missouri-Kansas City
5100 Rockhill Road
Kansas City, MO 64110-2499
(816) 235-2438

B.D. Owens Library
Northwest Missouri State University
800 University Drive
Maryville, MO 64468-6001
(660) 562-1841

St. Joseph Public Library
927 Felix Street
St. Joseph, MO 64501-2799
(816) 232-8151

Hearnes Learning Resources Ctr.
Missouri Western State University
4525 Downs Drive
St. Joseph, MO 64507-2294
(816) 271-5802

Library
North Central Missouri College
PO Box 111, 1301 Main Street
Trenton, MO 64683-0107
(660) 359-3948 ext. 325

Spiva Library
Missouri Southern State University
3950 East Newman Road
Joplin, MO 64801-1595
(417) 625-9342

Missouri State Library
600 West Main, PO Box 387
Jefferson City, MO 65102-0387
(573) 751-3615

Missouri State Archives
600 West Main, PO Box 778
Jefferson City, MO 65102-0778
(573) 526-6711

Elmer Ellis Library
University of Missouri-Columbia
106 B Ellis Library
Columbia, MO 65211-5149
(573) 882-0748

Library
State Historical Society of Missouri
1020 Lowry St.
Columbia, MO 65211-7298
(573) 882-9369

Daniel Boone Regional Library
PO Box 1267, 100 West Broadway
Columbia, MO 65205-1267
(573) 443-3161 ext. 359

School of Law
University of Missouri-Columbia
224 Hulston Hall
Columbia, MO 65211-0001
(573) 882-1125

Smiley Memorial Library
Central Methodist University
411 Central Methodist Square
Fayette, MO 65248-1198
(660) 248-6279

Library
Missouri University of Science and
Technology
1870 Miner Circle
Rolla, MO 65409-0060
(573) 341-4007

Lebanon-Laclede County Library
135 Harwood Ave.
Lebanon, MO 65536-3017
(417) 532-2148

University Library
Southwest Baptist University
1600 University Ave.
Bolivar, MO 65613-2597
(417) 328-1631

Barry-Lawrence Regional Library
213 6th St.
Monett, MO 65708-2147
(417) 235-6646

Lyons Memorial Library
College of the Ozarks
General Delivery
Point Lookout, MO 65726-9999
(417) 334-6411 ext. 3551

Garnett Library
Missouri State University—West
Plains
304 Cleveland
West Plains, MO 65775-3414
(417) 255-7945

Springfield-Greene County Library
4653 S. Campbell
Springfield, MO 65801-0760
(417) 874-8110

Meyer Library
Missouri State University
PO Box 175, 901 S. National
Springfield, MO 65804-0095
(417) 836-4533

HOW TO CITE RULES AND RSMo

RULES—Cite material in the *Missouri Register* by volume and page number, for example, Vol. 28, *Missouri Register*, page 27. The approved short form of citation is 28 MoReg 27.

The rules are codified in the *Code of State Regulations* in this system—

Title	***Code of State Regulations***	**Division**	**Chapter**	**Rule**
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division within the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

RSMo—The most recent version of the statute containing the section number and the date.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2000. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety, or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons, and findings which support its conclusion that there is an immediate danger to the public health, safety, or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten (10) days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

Title 6—DEPARTMENT OF HIGHER EDUCATION
Division 250—University of Missouri
Chapter 11—Administration of Missouri Fertilizer Law

EMERGENCY RULE

6 CSR 250-11.041 Inspection Fee on Manipulated Animal or Vegetable Manure Fertilizers

PURPOSE: This rule establishes the inspection fee on manipulated animal or vegetable manure fertilizers sold in the state.

EMERGENCY STATEMENT: This emergency rule informs state agencies and the public that a new fee structure for manipulated manure fertilizers has been implemented by the Missouri Legislature. This emergency rule is necessary because of new statute language adopted on May 15, 2009, and signed on July 7, 2009, that went into force on August 28, 2009. There is a default fee of thirty cents (30¢) per ton written into section 266.331, RSMo, for fertilizer classifications on which rules have not been developed which could cause distributors of these types of products to pay higher fees than the legislature has imposed. A proposed rule has been filed; however, it will not go into effect until after the next fee is required to be paid by the distributors which could result in higher fees or penalties to those distributors. A proposed rule, which covers the same material, was published in the ***Missouri Register*** *on December 15, 2009 (34 MoReg 2592–2593). The scope of this emergency rule is limited to the circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The Missouri Agricultural Experiment Station believes this emergency rule is fair to all interested persons and parties under the circumstances. This emergency rule was filed on December 22, 2009, becomes effective January 1, 2010, and expires June 28, 2010.*

(1) The fee provided to be established by rule under section 266.331, RSMo, for manipulated animal or vegetable manure fertilizers. Manipulated manure fertilizers shall be guaranteed. The fee established at two cents (2¢) per ton per percent nitrogen for nitrogen levels less than five percent (5%), four cents (4¢) per ton per percent nitrogen for nitrogen levels of five percent (5%) but less than ten percent (10%), or six cents (6¢) per ton per percent nitrogen for nitrogen levels of ten percent (10%) or greater.

AUTHORITY: section 266.331, HB 734, Ninety-fifth General Assembly 2009. Original rule filed Nov. 13, 2009. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 28, 2010.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 15—Hospital Program

EMERGENCY AMENDMENT

13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology. The division is amending sections (3), (15), (16), and (18).

PURPOSE: This amendment provides for the State Fiscal Year (SFY) 2010 trend factor, revises the better of days calculation for all hospitals, revises the utilization adjustment for all hospitals except for safety net hospitals, clarifies disproportionate share hospital (DSH) calculation to allow for payment up to one hundred percent (100%) of DSH allotment, and defines DSH cap.

EMERGENCY STATEMENT: The Department of Social Services, MO HealthNet Division by rule and regulation must define the reasonable costs, manner, extent, quantity, quality, charges, and fees of medical assistance. Due to the growing obligations on the Federal Reimbursement Allowance (FRA) Fund and the limited FRA resources, the FRA Fund balance has been deteriorating. A review of the payment calculations that obligate the FRA Fund was necessary to sustain a reasonable balance in the fund so that hospital payments could continue to be made. The MO HealthNet Division (MHD) has been reviewing its hospital Direct Medicaid payments including the manner for estimating Medicaid patient days, which uses a better of days methodology. The most notable finding was the excess Medicaid patient days estimated for some Missouri hospitals, as the estimated days simply have not materialized. MHD determined that the better of days methodology needed to be phased out so that the estimated days were more in line with actual days. This emergency amendment establishes the calculation of the Direct Medicaid payments effective for dates of service beginning January 1, 2010, to ensure that quality health care continues to be provided to MO HealthNet participants at hospitals that have relied on MO HealthNet payments to meet those patients' needs. This emergency amendment will ensure payment to Missouri hospitals providing health care to over eight hundred sixty thousand (860,000) Missourians eligible for the MO HealthNet program plus the uninsured. The MO HealthNet Division finds an immediate danger to public health, safety, and/or welfare and a compelling governmental interest which requires emergency action. The MO HealthNet program has a compelling government interest in providing continued cash flow for inpatient hospital services. The scope of this emergency amendment is limited to the circumstances creating the

*emergency and complies with the protections extended by the **Missouri** and **United States Constitutions**. The MO HealthNet Division believes this emergency amendment is fair to all interested persons and parties under the circumstances. A proposed amendment covering this same material was published in the **Missouri Register** on September 1, 2009 (34 MoReg 1802–1805). The final order of rulemaking relating to that proposed amendment includes changes as a result of comments received on the proposed amendment and was filed with the Joint Committee on Administrative Rules on November 25, 2009, and will be filed with the secretary of state December 28, 2009. Therefore, the division believes this emergency to be fair to all interested persons and parties under the circumstances. This emergency amendment was filed December 18, 2009, becomes effective January 1, 2010, and expires June 29, 2010.*

(3) Per Diem Reimbursement Rate Computation. Each hospital shall receive a MO HealthNet per diem rate based on the following computation.

(B) Trend Indices (TI). Trend indices are determined based on the four (4)-quarter average DRI Index for DRI-Type Hospital Market Basket as published in *Health Care Costs* by DRI/McGraw-Hill for each State Fiscal Year (SFY) 1995 to 1998. Trend indices starting in SFY 1999 will be determined based on CPI Hospital indexed as published in *Health Care Costs* by DRI/McGraw-Hill for each State Fiscal Year (SFY).

1. The TI are—
   A. SFY 1994—4.6%
   B. SFY 1995—4.45%
   C. SFY 1996—4.575%
   D. SFY 1997—4.05%
   E. SFY 1998—3.1%
   F. SFY 1999—3.8%
   G. SFY 2000—4.0%
   H. SFY 2001—4.6%
   I. SFY 2002—4.8%
   J. SFY 2003—5.0%
   K. SFY 2004—6.2%
   L. SFY 2005—6.7%
   M. SFY 2006—5.7%
   N. SFY 2007—5.9%
   O. SFY 2008—5.5%
   P. SFY 2009—5.5%
   Q. SFY 2010—3.9%

2. The TI for SFY 1996 through SFY 1998 are applied as a full percentage to the OC of the per diem rate and for SFY 1999 the OC of the June 30, 1998**,** rate shall be trended by 1.2% and for SFY 2000 the OC of the June 30, 1999**,** rate shall be trended by 2.4%. The OC of the June 30, 2000**,** rate shall be trended by 1.95% for SFY 2001.

3. The per diem rate shall be reduced as necessary to avoid any negative Direct Medicaid Payments computed in accordance with subsection (15)(B).

(15) Direct Medicaid Payments.

(B) Direct Medicaid payment will be computed as follows:

1. The MO HealthNet share of the inpatient FRA assessment will be calculated by dividing the hospital's inpatient Medicaid patient days by the total inpatient hospital patient days from the hospital's base cost report to arrive at the inpatient Medicaid utilization percentage. This percentage is then multiplied by the inpatient FRA assessment for the current SFY to arrive at the increased allowable MO HealthNet costs for the inpatient FRA assessment. The MO HealthNet share of the outpatient FRA assessment will be calculated by dividing the hospital's outpatient MO HealthNet charges by the total outpatient hospital charges from the base cost report to arrive at the MO HealthNet utilization percentage. This percentage is then multiplied by the outpatient FRA assessment for the current SFY to arrive at the increased allowable MO HealthNet costs for the outpatient FRA assessment;

2. The unreimbursed MO HealthNet costs are determined by subtracting the hospital's per diem rate from its trended per diem costs. The difference is multiplied by the estimated MO HealthNet patient days for the current SFY plus the out-of-state days from the fourth prior year cost report trended to the current SFY. The estimated MO HealthNet patient days for the current SFY shall be the better of the sum of the Fee-for-Service (FFS) days plus managed care days or the days used in the prior SFY's Direct Medicaid payment calculation. The FFS days are determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior SFY. The managed care days are based on the FFS days determined from the regression analysis, as follows: The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report. The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

A. Effective January 1, 2010, the estimated MO HealthNet patient days shall be the better of the sum of the FFS days plus managed care days or the days used in the prior SFY's Direct Medicaid payment calculation (i.e., for SFY 2010, prior SFY would be SFY 2009) adjusted downward by twenty-five percent (25%) of the difference between the sum of the FFS days plus managed care days and the days used in the prior SFY's Direct Medicaid payment calculation.

(I) The FFS days plus managed care days are determined as follows: The FFS days are determined by applying a trend to the second prior Calendar Year (CY) days (i.e., for SFY 2010, second prior CY would be 2008) as determined from the state's Medicaid Management Information System (MMIS). The trend is determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior CY. The managed care days are based on the FFS days determined from the regression analysis, as follows: The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report. The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

(II) The days used in the prior SFY's Direct Medicaid payment calculation adjusted downward by twenty-five percent (25%) are determined as follows: The days used in the prior SFY's Direct Medicaid payment calculation are compared to the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I). If the hospital has greater estimated days as used in the prior SFY's Direct Medicaid payment calculation than the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I), the difference between the days is multiplied by twenty-five percent (25%), and this amount is removed from the estimated days used in the prior SFY's Direct Medicaid payment calculation to arrive at the current year's estimated days.

B. Effective July 1, 2010, the estimated MO HealthNet patient days shall be the better of the sum of the FFS days plus managed care days or the days used in the prior SFY's Direct Medicaid payment calculation (i.e., for SFY 2011, prior SFY would be SFY 2010) adjusted downward by fifty percent (50%) of the difference between the sum of the FFS days plus managed care days and the days used in the prior SFY's Direct Medicaid payment calculation.

(I) The FFS days plus managed care days are determined as set forth in part (15)(B)2.A.(I).

(II) The days used in the prior SFY's Direct Medicaid payment calculation adjusted downward by fifty percent (50%) are determined as follows: The days used in the prior SFY's Direct Medicaid payment calculation are compared to the sum of the FFS days plus managed care days as determined in part

(15)(B)2.A.(I). If the hospital has greater estimated days as used in the prior SFY's Direct Medicaid payment calculation than the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I), the difference between the days is multiplied by fifty percent (50%) and this amount is removed from the estimated days used in the prior SFY's Direct Medicaid payment calculation to arrive at the current year's estimated days.

C. Effective July 1, 2011, the estimated MO HealthNet patient days shall be the better of the sum of the FFS days plus managed care days or the days used in the prior SFY's Direct Medicaid payment calculation (i.e., for SFY 2012, prior SFY would be SFY 2011) adjusted downward by seventy-five percent (75%) of the difference between the sum of the FFS days plus managed care days and the days used in the prior SFY's Direct Medicaid payment calculation.

(I) The FFS days plus managed care days are determined as set forth in part (15)(B)2.A.(I).

(II) The days used in the prior SFY's Direct Medicaid payment calculation adjusted downward by seventy-five percent (75%) are determined as follows: The days used in the prior SFY's Direct Medicaid payment calculation are compared to the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I). If the hospital has greater estimated days as used in the prior SFY's Direct Medicaid payment calculation than the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I), the difference between the days is multiplied by seventy-five percent (75%) and this amount is removed from the estimated days used in the prior SFY's Direct Medicaid payment calculation to arrive at the current year's estimated days.

D. Effective July 1, 2012, the estimated MO HealthNet patient days shall be the sum of the FFS days plus managed care days. The FFS days plus managed care days are determined as set forth in part (15)(B)2.A.(I).

*[A.]***E.** The trended cost per day is calculated by trending the base year costs per day by the trend indices listed in paragraph (3)(B)1., using the rate calculation in subsection (3)(A). In addition to the trend indices applied to inflate base period costs to the current fiscal year, base year costs will be further adjusted by a Missouri Specific Trend. The Missouri Specific Trend will be used to address the fact that costs for Missouri inpatient care of MO HealthNet residents have historically exceeded the compounded inflation rates estimated using national hospital indices for a significant number of hospitals. The Missouri Specific Trend will be applied at one and one-half percent (1.5%) per year to the hospital's base year. For example, hospitals with a 1998 base year will receive an additional six percent (6%) trend, and hospitals with a 1999 base year will receive an additional four and one-half percent (4.5%) trend.

*[B.]***F.** For hospitals that meet the requirements in paragraphs (6)(A)1., (6)(A)2., and (6)(A)4. of this rule (safety net hospitals), the base year cost report may be from the third prior year, the fourth prior year, or the fifth prior year. For hospitals that meet the requirements in paragraphs (6)(A)1. and (6)(A)3. of this rule (first tier Disproportionate Share Hospitals), the base year operating costs may be the third or fourth prior year cost report. The MO HealthNet Division shall exercise its sole discretion as to which report is most representative of costs. For all other hospitals, the base year operating costs are based on the fourth prior year cost report. For any hospital that has both a twelve (12)-month cost report and a partial year cost report, its base period cost report for that year will be the twelve (12)-month cost report.

*[C.]***G.** The trended cost per day does not include the costs associated with the FRA assessment, the application of minimum utilization, the utilization adjustment, and the poison control costs computed in paragraphs (15)(B)1., 3., 4., and 5.;

3. The minimum utilization costs for capital and medical education is calculated by determining the difference in the hospital's cost per day when applying the minimum utilization as identified in paragraph (5)(C)4., and without applying the minimum utilization. The difference in the cost per day is multiplied by the estimated MO HealthNet patient days for the SFY;

4. The utilization adjustment cost is determined by estimating the number of MO HealthNet inpatient days the hospital will not provide as a result of the managed care health plans limiting inpatient hospital services. These days are multiplied by the hospital's cost per day to determine the total cost associated with these days. This cost is divided by the remaining total patient days from its base period cost report to arrive at the increased cost per day. This increased cost per day is multiplied by the estimated MO HealthNet days for the current SFY to arrive at the MO HealthNet utilization adjustment.

A. Effective January 1, 2010, hospitals other than safety net hospitals as defined in subsection (6)(B) will receive sixty-seven percent (67%) of the utilization adjustment calculated in accordance with paragraph (15)(B)4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph (15)(B)4.

B. Effective July 1, 2010, hospitals other than safety net hospitals as defined in subsection (6)(B), children's hospitals as defined in subsection (2)(S), and specialty pediatric hospitals as defined in subsection (2)(P) will receive thirty-four percent (34%) of the utilization adjustment calculated in accordance with paragraph (15)(B)4. Children's hospitals and specialty pediatric hospitals will receive fifty percent (50%) of the adjustment calculated in accordance with paragraph (15)(B)4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph (15)(B)4.

C. Effective July 1, 2011, the utilization adjustment will no longer apply to any hospital other than safety net hospitals as defined in subsection (6)(B), children's hospitals as defined in subsection (2)(S), and specialty pediatric hospitals as defined in subsection (2)(P). Children's hospitals and specialty pediatric hospitals will continue to receive fifty percent (50%) of the adjustment calculated in accordance with paragraph (15)(B)4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph (15)(B)4.;

5. The poison control cost shall reimburse the hospital for the prorated MO HealthNet managed care cost. It will be calculated by multiplying the estimated MO HealthNet share of the poison control costs by the percentage of managed care participants to total MO HealthNet participants; and

6. Prior to July 1, 2006, the costs for including out-of-state Medicaid days is calculated by subtracting the hospital's per diem rate from its trended per diem cost and multiplying this difference by the out-of-state Medicaid days from the base year cost report. Effective July 1, 2006, the costs for including out-of-state Medicaid days is calculated by subtracting the hospital's per diem rate from its trended per diem cost and multiplying this difference by the out-of-state Medicaid days as determined from the regression analysis performed using the out-of-state days from the fourth, fifth, and sixth prior year cost reports.

(16) Safety Net Adjustment. A safety net adjustment, in lieu of the Direct Medicaid Payments and Uninsured Add-Ons, shall be provided for each hospital which qualified as disproportionate share under the provision of paragraph (6)(A)4. The safety net adjustment payment shall be made prior to the end of each federal fiscal year.

(A) The safety net adjustment for facilities which qualify under subparagraph (6)(A)4.B. or (6)(A)4.C. of this regulation shall be computed in accordance with the Direct Medicaid Payment calculation described in section (15) and the uninsured costs calculation described in subsection (18)(D) of this regulation. *[The safety net adjustment for the facilities that qualify under this subsection shall be calculated by adding an additional ten percent (10%) to the percentage that will be used to distribute either the total annual projected cost of the uninsured population that is related to hospital services, or the DSH cap for hospitals, whichever is lower (i.e., if ninety percent (90%) is*

used to distribute the annual projected cost of the uninsured population that is related to hospital services or the DSH cap for hospitals, whichever is lower, then one hundred percent (100%) would be used for the facilities that qualify under this subsection).] The safety net adjustment will include the last three (3) quarters of the SFY ending June 30 and the first quarter of the next SFY beginning July 1 to correspond with the FFY of October 1 to September 30.

(18) In accordance with state and federal laws regarding reimbursement of unreimbursed costs and the costs of services provided to uninsured patients, reimbursement for each State Fiscal Year (SFY) (July 1–June 30) shall be determined as follows:

(E) Uninsured Add-Ons effective July 1, 2009, for all facilities except Department of Mental Health (DMH) safety net facilities as defined in subparagraph (6)(A)4.D. DMH safety net facilities will continue to be calculated in accordance with subsection (18)(B). The Uninsured Add-On for all facilities except DMH safety net facilities will be based on the following:

1. Determination of the cost of the uninsured:

A. Allocate the uninsured population as determined from the Current Population Survey (CPS), Annual Social and Economic Supplement (Table HI05) as published by the U.S. Census Bureau, to the same categories of age (COA) and age groups as the managed care rate cells as determined by the Managed Care Unit of the MO HealthNet Division;

B. Determine the total annual projected cost of the uninsured population by multiplying the number of uninsured for each rate cell by the average contract per member per month (PMPM) for that individual managed care rate cell multiplied by twelve (12); and

C. Determine the amount of the total annual projected cost of the uninsured population that is related to hospital services by multiplying the total annual projected cost of the uninsured population as calculated in paragraph (18)(E)1. above by the percentage of the contract PMPM for each individual rate cell that is related to hospital services. This would be the maximum amount of uninsured add-on payments that could be made to hospitals. This amount is also subject to the DSH cap;

2. Proration to individual hospitals of the cost of the uninsured calculated in paragraph (18)(E)1.—

A. Determine each individual hospital's Uninsured Add-On payment by dividing the individual hospital's uninsured cost as determined from the three (3)-year average of the fourth, fifth, and sixth prior base year cost reports by the total uninsured cost for all hospitals as determined from the three (3)-year average of the fourth, fifth, and sixth prior base year cost reports, multiplied by either the total annual projected cost of the uninsured population that is related to hospital services or the DSH cap for hospitals, whichever is lower. The DSH cap for hospitals is the federal DSH allotment less the IMD allotment less any redirections of DSH for Medicaid coverage of uninsured individuals as authorized by appropriation; and

B. Hospitals which qualify as safety net hospitals under subparagraphs (6)(A)4.B. and (6)(A)4.C. shall receive payment up to one hundred percent (100%) of their proration. The percentage of proration payable to non-safety net hospitals shall be up to ninety-nine percent (99%), unless the hospital contributes through a plan that is approved by the director of the Department of Health and Senior Services to support the state's poison control center and the Primary Care Resource Initiative for Missouri (PRIMO) and Patient Safety Initiative, in which case they shall receive up to one hundred percent (100%); and

3. For new hospitals that do not have a base year cost report, uninsured payments shall be estimated as follows:

A. Hospitals receiving uninsured payments shall be divided into quartiles based on total beds;

B. Uninsured payments shall be individually summed by quartile and then divided by the total beds in the quartile to yield an average uninsured payment per bed; and

C. The numbers of beds for the new hospital without the base year cost report shall be multiplied by the average uninsured payment per bed.

*[(E)]***(F)** Uninsured Add-On payments will coincide with the semimonthly claim payment schedule established by the MO HealthNet fiscal agent. Each hospital's semimonthly add-on payment shall by the hospital's total cost of the uninsured as determined in *[sub]*section (18)*[(D),]* divided by the number of semimonthly pay dates available to the hospital in the state fiscal year.

*AUTHORITY: sections 208.152, 208.153, 208.201, and 208.471, RSMo Supp. [2007] **2008**. This rule was previously filed as 13 CSR 40-81.050. Original rule filed Feb. 13, 1969, effective Feb. 23, 1969. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Aug. 3, 2009. Emergency amendment filed Dec. 18, 2009, effective Jan. 1, 2010, expires June 29, 2010.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.010 Definitions. The Missouri Consolidated Health Care Plan is deleting sections (2), (7), (8), (10), (64), (66), (79), and (81); renumbering and amending sections (3)–(6), (9), (11)–(63), (65), (67)–(78), (80), and (82)–(92); and adding new sections (6), (9)–(12), (14)–(18), (20), (24), (30), (34), (35), (41), (43), (45)–(47), (49), (50), (53), (59), (60), (64), (69), (70), (72), (76), (80), (82), (83), (99), (101), (102), (104), (106), (108)–(110), (114), (116), (119), (122), (125)–(127), and (130).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the definitions of the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be effective immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or

expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

[(2) Actively at work. You are considered actively at work when performing in the customary manner all of the regular duties of your occupation with the employer either at one (1) of the employer's regular places of business or at some location which the employer's business requires you to travel to perform your regular duties or other duties assigned by your employer. You are also considered to be actively at work on each day of a regular paid vacation or nonworking day on which you are not totally disabled, but only if you are performing in the customary manner all of the regular duties of your occupation with the employer on the immediately preceding regularly scheduled workday.]

*[(3)]***(2)** Administrative appeal. *[Appeal procedures]* **A written request submitted by or on behalf of a member** involving Missouri Consolidated Health Care Plan (MCHCP) administrative issues such as eligibility, effective date**s** of coverage, **plan changes,** etc.

*[(4)]***(3)** Administrative guidelines. *[The]* **Instructive** interpretation of the plan document *[as approved by the plan administrator,]* developed for administration of the plan. The administrative guidelines may be changed upon approval of the executive director or his/her designee. Benefits provided shall be those in effect at the time services are rendered.

*[(5)]***(4)** Adverse determination. When the claims administrator reviews an admission, availability of care, continued stay**,** or other health care service and decides that it is not medically necessary, appropriate**,** or effective. Therefore, payment for the requested service is denied, reduced**,** or terminated.

*[(6)]***(5)** Allowable expense. Charges for services rendered or supplies furnished by a health plan that would qualify as covered expenses and for which the program pays in whole or in part, subject to any deductible, coinsurance, or table of allowance included in the program.

[(7) Automatic reinstatement maximum. The maximum annual amount that can be reinstated to an individual's lifetime benefit.

(8) Benefit year. The twelve (12)-month period beginning January 1 and ending December 31. All annual deductibles and benefit maximums accumulate during the benefit year.]

(6) Appeal. A written complaint submitted by or on behalf of a member regarding one (1) of the following:

(A) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or

(B) Claim payment, handling, or reimbursement for pharmacy benefits or health care services.

(7) Benefit period. The three hundred sixty-five (365) days immediately following the first date of like services.

*[(9)]***(8)** Benefits. Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator.

[(10) Care Support Program. A voluntary program that helps manage a chronic condition with outpatient treatment.]

(9) Birthday rule. If both parents have medical coverage, the primary plan for dependent children is the plan of the parent whose birthday occurs first in the calendar year. If birthdays occur on the same day, the parent's coverage that has been in effect longest is primary.

(10) Board. The board of trustees of the Missouri Consolidated Health Care Plan.

(11) Calendar year. The period of time from January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All annual deductibles and benefit maximums accumulate during the calendar year.

(12) Chiropractic services. The examination, diagnosis, adjustment, manipulation, and treatment of malpositioned articulations and structures of the body, directed toward restoring and maintaining the normal neuromuscular and musculoskeletal function and health.

*[(11)]***(13)** Claims administrator. An organization or group responsible for the processing of claims and associated services for the plan's self-insured benefit programs, including but not limited to the preferred provider organization (PPO) (also known as the co*[-]*pay plan) and health maintenance organization (HMO) type plans.

(14) Coinsurance. The shared portion of payment between the plan and the subscriber where each pays a percentage of covered charges.

(15) Comprehensive major medical. A plan that provides for cost sharing to be applied to all covered expenses such as deductible or coinsurance.

(16) Congenital defect. Existing or dating from birth. Acquired through development while in the uterus.

(17) Convenient care clinics (CCCs). Health care clinics located in retail stores, supermarkets, and pharmacies that treat routine family illnesses and provide preventive health care services. They are sometimes referred to as "retail-based clinics" or "walk-in medical clinics." CCCs are usually staffed by nurse practitioners or physician assistants. Some CCCs, however, are staffed by physicians.

(18) Coordination of benefits. Communication, adjustment, and reconciliation procedures between multiple benefit plans covering the same member for purposes of covering services and expenses relating to plan benefits.

*[(12)]***(19)** Co*[-]*pay plan. A set of benefits similar to a health maintenance organization option.

(20) Copayment. A set dollar amount that the covered individual must pay for specific services.

*[(13)]***(21)** Cosmetic surgery. A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than restore the anatomy and/or functions of the body which are lost or impaired due to illness or injury.

*[(14)]***(22)** Covered benefits **and charges**. A schedule of covered services and charges*[, including chiropractic services, which are]* payable under the plan. The benefits covered under each type of plan are outlined in the applicable rule in this chapter.

*[(15)]***(23)** Custodial care. Services and supplies furnished primarily to assist an individual to meet the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a health care provider or that do not entail *[or]*

and require the continuing attention of trained medical or paramedical personnel.

(24) Date of service. Date medical services are received or performed.

*[(16)]***(25)** Deductible. The amount of expense the member must pay before the plan begins to pay for covered services and supplies. This amount is not reimbursable by the plan.

*[(17)]***(26)** Dependent-only participation. Participation of certain survivors of *[employees]* **subscribers**. Dependent participation may be further defined to include the deceased *[employee's]* **subscriber's**:
(A) Spouse only;
(B) Child(ren) only; or
(C) Spouse and child(ren).

*[(18)]***(27)** Dependents. The lawful spouse of the employee, the employee's unemancipated child(ren)**,** and certain survivors of employees, as provided in the plan document and these rules, for whom application has been made and has been accepted for participation in the plan.

*[(19)]***(28)** Diagnostic charges. The Usual, Customary**,** and Reasonable (UCR) charges or the network discounted rate (NDR) for x-ray or laboratory examinations made or ordered by a physician in order to detect a medical condition.

*[(20)]***(29)** Disposable supplies. **Medical supplies that** *[D]***d**o not withstand prolonged use and are periodically replaced. Includes, but not limited to, colostomy and ureterostomy bags.

(30) Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:
(A) Doctor of medicine;
(B) Doctor of osteopathy;
(C) Podiatrist;
(D) Optometrist;
(E) Chiropractor;
(F) Psychologist;
(G) Doctor of dental surgery; or
(H) Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practice of spiritual healing are well established and recognized.

*[(21)]***(31)** Durable medical equipment (DME). Equipment able to withstand repeated use for the therapeutic treatment of an active illness or injury. Such equipment is not covered under the plan if it could be useful to a person in the absence of an illness or injury and could be purchased without a physician's prescription.

*[(22)]***(32)** Eligibility date. Refer to 22 CSR 10-2.020 for effective date provisions.
(A) Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of employment or reemployment.
(B) Employees transferred from a state department with coverage under another medical care plan into a state department covered by this plan and their eligible dependents who were covered by the other medical care plan *[will be]* **are** eligible for participation *[subject to any applicable pre-existing conditions as outlined in the plan document]* **immediately**.
(C) Employees who terminate all employment with the state (not simply move from one **(1)** agency to another) and are rehired as a new state employee before termination of participation, and their eligible dependents who were covered by the plan, will be eligible for participation immediately.
(D) Employees who terminate all employment with the state (not simply move from one **(1)** agency to another) and are rehired as a new state employee in the subsequent month, and their eligible dependents who were covered by the plan, will be eligible for participation retroactive to the date following termination of participation **or at the employee's choice, on the first day of the month following the employee's date of rehire**.

*[(23)]***(33)** Emancipated child(ren). A child(ren) who is:
(A) Employed on a full-time basis;
(B) Eligible for group health benefits in his/her own behalf;
(C) Maintaining a residence separate from his/her parents or guardian, except for full-time students in an accredited school or institution of higher learning; or
(D) Married.

(34) Emergency. Any medical condition leading a prudent layperson to seek immediate medical attention. This normally means the sudden onset of a health condition that manifests itself by acute symptoms and severity (including severe pain). Examples of medical emergencies include, but are not limited to:
(A) Conditions placing a person's health in significant jeopardy;
(B) Serious impairment to a bodily function;
(C) Serious dysfunction of any bodily organ or part;
(D) Inadequately controlled pain; or
(E) Situations when the health of a pregnant woman or her unborn child are threatened.

(35) Emergency room. The section of a hospital equipped to furnish emergency care to prevent the death or serious impairment of the covered person.

*[(24)]***(36)** Employee and dependent participation. Participation of an employee and the employee's eligible dependents. Any individual eligible for participation as an employee is not eligible as a dependent, except as noted in 22 CSR 10-2.020(1)(A)3. Dependent participation may be further defined to include the participating employee's:
(A) Spouse only;
(B) Child(ren) only; or
(C) Spouse and child(ren).

[(25) Employee only participation. Participation of an employee without participation of the employee's dependents, whether or not the employee has dependents.]

*[(26)]***(37)** Employees. Employees of the state and present and future retirees from state employment who meet the eligibility requirements as prescribed by state law.

*[(27)]***(38)** Employer. The state department **or agency** that employs the eligible employee as defined above.

*[(28)]***(39)** Executive director. The *[administrator]* **chief executive officer** of the Missouri Consolidated Health Care Plan (MCHCP) who *[reports directly to the plan administrator]* **shall have charge of the offices, records, and employees of the plan, subject to the direction of the board**.

*[(29)]***(40)** Experimental/Investigational/Unproven. A treatment, procedure, device**,** or drug that meets any of the criteria listed below is considered experimental/investigational/unproven*[,]* and is not eligible for coverage under the plan. Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community. Experimental/investigational/unproven is defined as a treatment, procedure, device**,** or

drug that the plan administrator determines, in the exercise of its discretion:

(A) Has not received the approval of the U.S. Food and Drug Administration for marketing the drug or device at the time it is furnished, if such approval is required by law;

(B) Is shown by reliable evidence to be the subject of ongoing Phase I clinical trials or under study to determine its maximum tolerated dose, its toxicity, **its** safety, **its** efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or

(C) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device**,** or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy**,** or its efficiency as compared with the standard means of treatment or diagnosis.

(41) First eligible. The first thirty-one (31)-day period after a member's employment date in which the member and his/her dependents may enroll in an MCHCP plan. As a member acquires new dependents, his/her first eligible period is the first thirty-one (31) days from the date the dependent meets the eligibility requirements for coverage under the plan.

*[(30)]***(42)** Formulary *[drugs]*. A list of drugs *[preferred]* **covered** by the **pharmacy program** claims administrator *[of the pharmacy program]* and as allowed by the plan administrator.

(43) Generic drug. The chemical equivalent of a brand-name drug with an expired patent. The color or shape may be different, but the active ingredients must be the same for both.

*[(31)]***(44)** Grievance. A written complaint submitted by or on behalf of a member regarding either:

(A) Availability, delivery**,** or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or

(B) Claims payment, handling**,** or reimbursement for health care services.

(45) Group health plan. A plan maintained by an employer or an employee organization to provide medical care or other health services, directly or indirectly, to employees, former employees, and their families, including but not limited to Medicare and Medicaid plans.

(46) Handbook. The summary plan document prepared for members explaining the terms, conditions, and all material aspects of the plan and benefits offered under the plan, a copy of which is incorporated by reference into this rule. The full text of material incorporated by reference will be made available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, 2010 State Member Handbook (January 1, 2010). It does not include any later amendments or additions.

(47) Health assessment. A questionnaire about a member's health and lifestyle habits which qualifies the member for participation in the *Lifestyle Ladder* program to earn the incentive premium.

*[(32)]***(48)** Health maintenance organization (HMO). A plan that provides for a wide range of comprehensive health care services for a specified group at a fixed periodic prepayment.

(49) Health savings account (HSA). A tax-advantaged savings account that may be used to pay current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA. HSA funds can be used to help pay the deductible, coinsurance, and any qualified medical expenses not covered by the health plan.

(50) High Deductible Health Plan (HDHP). A health plan with higher deductibles than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

*[(33)]***(51)** Home health agency. An agency certified by **Medicare and** the Missouri Department of Health and Senior Services, or any other state's licensing or certifying body, to provide health care services to persons in their homes.

*[(34)]***(52)** Hospice. *[A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill.]* **A public agency, private organization, or a subdivision of either that primarily engages in providing care to terminally ill individuals, meets the conditions of participation for hospices, holds a valid Medicare provider agreement, and is licensed pursuant to state law.**

(53) Hospice facility. A public or private organization, certified by Medicare and any other state's licensing or certifying body, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill. The facility must have an interdisciplinary medical team consisting of at least one (1) physician, one (1) registered nurse, one (1) social worker, one (1) volunteer, and a volunteer program. A hospice facility is not a facility or part thereof which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics, or a hotel or similar institution.

*[(35)]***(54)** Hospital.

(A) An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic**,** and surgical facilities, all of which must be provided on its premises, under the supervision of a staff of one (1) or more physicians and with twenty-four (24)-hour-a-day nursing service by a registered nurse (RN) on duty or call.

(B) An institution not meeting all the requirements of *[(35)]***(54)**(A) *[of this rule]* **above**, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

(C) An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of Public Law 89-97).

(D) A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.

(E) A residential alcoholism, chemical dependency**,** or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction.

(F) In no event shall the term hospital include a skilled nursing facility or any institution or part thereof which is used primarily as a skilled nursing facility, nursing home, rest home**,** or facility for the aged.

*[(36)]***(55)** Hospital copayment. Set dollar amount a subscriber must pay for each hospital admission.

*[(37)]***(56)** Hospital room charges. The hospital's most common charge for semi-private accommodations, *[unless]* **or the most common charge for a private room if that is the only type of room available or if** a private room has been recommended by a physician and approved by the claims administrator or the plan administrator.

*[(38)]***(57)** Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered as any other illness.

*[(39)]***(58)** Incident. A definite and separate occurrence of a condition.

(59) Infertility. Any medical condition causing the inability or diminished ability to reproduce.

(60) Infertility services. Services including confinement, treatment, or other services related to the restoration of fertility or the promotion of conception.

*[(40)]***(61)** Injury. A condition that results independently of an illness and all other causes and is a result of an external force or accident.

*[(41)]***(62)** Inpatient. Confined to a registered bed. Patient in hospital, skilled nursing facility, hospice **facility,** or free-standing chemical dependency treatment center.

*[(42)]***(63)** Legend. Any drug that requires a prescription from either a physician or a practitioner, under either federal or applicable state law, in order to be dispensed.

(64) Life events. Events occurring in an individual's life to include: marriage, birth, adoption, or placement of children.

*[(43)]***(65)** Lifetime. The period of time *[you or your]* **a member or the member's** eligible dependents participate in the plan.

*[(44)]***(66)** Lifetime maximum. The maximum amount payable by a medical plan during a covered member's life.

*[(45)]***(67)** Medical benefits coverage. Services that are received from providers recognized by the plan and are covered benefits under the plan.

*[(46)]***(68)** Medically necessary. Treatments, procedures, services**,** or supplies that the plan administrator determines, in the exercise of its discretion:

(A) Are expected to be of clear clinical benefit to the patient; and

(B) Are appropriate for the care and treatment of the injury or illness in question; and

(C) Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service**,** or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a *[health care]* provider has prescribed, ordered**,** or recommended a treatment, procedure, service**,** or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service**,** or supply must not be specifically excluded from coverage under this plan.

(69) Member. Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

(70) Morbid obesity. Body Mass Index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled comorbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions approved by the plan administrator based on clinical review.

*[(47)]***(71)** Network provider. A physician, hospital, pharmacy, etc., that is contracted with the *[medical]* plan.

(72) Non-embedded deductible. The family deductible that must be met before claim payments begin, applicable when two (2) or more family members are covered in the HDHP.

*[(48)]***(73)** Non-formulary. A drug not contained on the *[health plan's or the]* pharmacy program's formulary list *[or preferred drug list]* **but may be covered under the terms and conditions of the plan**.

*[(49)]***(74)** Non-network provider or non-participating provider. Any physician, hospital, pharmacy, etc., that does not have a contract with the *[health]* plan *[or the pharmacy program]*.

*[(50)]***(75)** Nurse. A registered nurse (RN), licensed practical nurse (LPN)**,** or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule.

(76) Nursing home. An institution operated, pursuant to law, primarily for custodial care or for patients convalescing from illness or injury, under the supervision of a physician or registered nurse and having twenty-four (24)-hour nursing care. Also, an institution meeting the preceding criteria which is established for the treatment of sick and injured persons through spiritual means and is operated under the authority of organizations which are recognized under Medicare.

*[(51)]***(77)** Open enrollment period. A period designated by the plan during which subscribers may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year.

*[(52)]***(78)** Out-of-area. Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria.

*[(53)]***(79)** Out-of-network. Providers that do not participate in the member's health **or pharmacy** plan.

(80) Out-of-pocket maximum. The maximum amount the member must pay before the plan begins paying one hundred percent (100%) of covered charges for the remainder of the calendar year.

*[(54)]***(81)** Outpatient. Treatment either outside a hospital setting or at a hospital when room and board charges are not incurred.

(82) Outpatient observation stay. Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Most observation services are less than twenty-four (24) hours. Members may receive observation services in the emergency room, an observation unit, the intensive care unit, or a regular floor.

(83) Palliative services. Care provided by a team approach that improves the quality of life for patients and their families facing problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

*[(55)]***(84)** Partial hospitalization. A distinct and organized intensive ambulatory treatment service, less than twenty-four (24)-hour daily care specifically designed for the diagnosis and active treatment of a mental/nervous disorder when there is a reasonable expectation for

improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.

(A) Partial hospitalization programs must provide diagnostic services; services of social workers; psychiatric nurses and staff trained to work with psychiatric patients; individual, group**,** and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions for therapeutic purposes.

(B) The facility providing the partial hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a physician.

*[(56)]***(85)** Participant. Any employee or dependent accepted for membership in the plan.

*[(57)]***(86)** Pharmacy benefit manager (PBM). Acts as a link between the parties involved in the delivery of prescription drugs to health plan members. The PBM designs, implements, **and** manages the overall drug benefit of the plan*[,]* and processes claims payments.

*[(58)]***(87)** Physically or mentally disabled. The inability of a person to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition.

*[(59)]***(88)** Physician/Doctor. A licensed practitioner of the healing arts, acting within the scope of his/her practice as licensed under section 334.021, RSMo.

*[(60)]***(89)** Plan. The program of health care benefits established by the trustees of the Missouri Consolidated Health Care Plan as authorized by state law.

*[(61)]***(90)** Plan administrator. The trustees of the Missouri Consolidated Health Care Plan. As such, the board is the sole fiduciary of the plan, has all discretionary authority to interpret its provisions and to control the operation and administration of the plan, and whose decisions are final and binding on all parties.

*[(62)]***(91)** Plan document. The statement of the terms and conditions of the plan as promulgated by the plan administrator in this chapter.

*[(63)]***(92)** Plan year. Same as *[benefit]* **calendar** year.

[(64) Point-of-service (POS). A plan which provides a wide range of comprehensive health care services, like an HMO, if in-network providers are utilized, and like a PPO plan, if non-network providers are utilized.]

*[(65)]***(93)** Pre-admission testing. X-rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission.

[(66) Pre-authorization. A cost control procedure that requires the service or medication to be approved in advance by the doctor and/or the plan. Without prior authorization, the plan may not pay for the test, drug, or service.]

*[(67)]***(94)** Pre-certification *[program]*. Also known as pre-admission certification, pre-admission review, and pre-certification. The process of obtaining certification or authorization from the plan for routine hospital admissions and surgical or diagnostic procedures (inpatient or outpatient).

*[(68)]***(95)** Pre-existing condition. A condition for which *[you have]* **a member has** incurred medical expenses or received treatment *[within the three (3) months]* prior to *[your]* **the** effective date of coverage.

*[(69)]***(96)** Preferred provider organization (PPO). An arrangement with providers where discounted rates are given to members of the plan who, in turn, are offered a financial incentive to use these providers.

*[(70)]***(97)** Prevailing fee. The fee charged by the majority of dentists.

*[(71)]***(98)** Primary care physician (PCP). A physician (usually an internist, family/general practitioner**,** or pediatrician) who has contracted with and been approved by *[an HMO or POS. The PCP is accountable for all medical services of members including referrals. The PCP supervises other provided care such as services of specialists and hospitalization]* **a medical plan**.

(99) Prior authorization. A cost control procedure that requires the service or medication to be approved in advance by the doctor and/or the plan. Without prior authorization, the plan may not pay for the test, drug, or service. Also know as pre-authorization or pre-notification.

*[(72)]***(100)** Prior plan. The terms and conditions of a plan in effect for the period preceding coverage in the *[MCHCP]* **plan**.

(101) Private duty nursing. Private duty nursing services, nursing care on a full-time basis in the member's home, or home health aides.

(102) Proof of eligibility. Documentation required by the plan to determine a dependent's qualification for health insurance coverage.

*[(73)]***(103)** Proof of insurance. Evidence in written form from an insurance company that provides verification of coverage for a given period of time.

(104) Proof of prior group coverage. If a member or his/her dependents enroll in the plan due to loss of coverage, the member must provide proof of prior group coverage. This includes a letter from the previous insurance carrier or former employer which states all the following:

(A) Date coverage was or will be terminated;

(B) Reason for coverage termination; and

(C) List of dependents covered.

*[(74)]***(105)** Prostheses. An artificial extension that replaces a missing part of the body. Prostheses are typically used to replace parts lost by injury (traumatic) or missing from birth (congenital) or to supplement defective parts.

(106) Protected health information. Any information, whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse. This information also relates to the past, present, or future physical or mental health or condition of the individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to the individual.

*[(75)]***(107)** Provider. Hospitals, physicians, chiropractors, medical agencies, or other specialists who provide medical care within the scope of his/her practice and are recognized under the provisions *[and administrative guidelines]* of the plan. Provider also includes a qualified practitioner of an organization which is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

(108) Provider directory. A listing of network providers within a health plan.

(109) Prudent layperson. An individual possessing an average knowledge of health and medicine.

(110) Qualified Medical Child Support Order (QMCSO). A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or an enrollee if the plan normally provides coverage for dependent children.

*[(76)]***(111)** Reconstructive surgery. A procedure performed to restore the anatomy and/or functions of the body that are lost or impaired due to an injury or illness.

*[(77)]***(112)** Refractions. A record of the patient's preference for the focusing of the eyes that can then be used to purchase eyeglasses. It is the portion of the eye exam that determines what prescription lens provides the patient with the best possible vision.

*[(78)]***(113)** Rehabilitation facility. A legally operating institution**,** or distinct part of an institution**,** that has a transfer agreement with one **(1)** or more hospitals and is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute hospital**,** and rehabilitative inpatient care and is duly licensed by the appropriate government agency to provide such services.

(A) It does not include institutions that provide only minimal care, custodial care, ambulatory or part-time care services, or an institution that primarily provides treatment of mental/nervous disorders, substance abuse**,** or tuberculosis, except if such facility is licensed, certified**,** or approved as a rehabilitation facility for the treatment of mental/nervous conditions or substance abuse in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) or the Commission for the Accreditation of Rehabilitation Facilities.

(114) Retiree. A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-2.020(5)(B) and is currently receiving a monthly retirement benefit from one (1) of the retirement systems listed in such rule.

[(79) Review agency. A company responsible for administration of clinical management programs.]

*[(80)]***(115)** Second opinion program. A consultation and/or exam with a physician qualified to perform the procedure who is not affiliated with the attending physician/surgeon, for the purpose of evaluating the medical necessity and advisability of undergoing a surgical procedure or receiving a service.

[(81) Severe obesity. Body Mass Index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hyptertension, hypertension or other obesity related conditions which will be considered based on clinical review.]

(116) Skilled nursing care. Care which must be performed by, or under the supervision of, licensed personnel and meets criteria as established by the claims administrator.

*[(82)]***(117)** Skilled nursing facility (SNF). An institution which meets fully each of the following requirements:

(A) It is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, the following services for persons convalescing from sickness or injury: room, board**,** and twenty-four (24)-hour-a-day nursing service by one (1) or more professional nurses and nursing personnel as are needed to provide adequate medical care;

(B) It provides the services under the supervision of a proprietor or employee who is a physician or registered nurse; and it maintains adequate medical records and has available the services of a physician under an established agreement, if not supervised by a physician or registered nurse; and

(C) A skilled nursing facility shall be deemed to include institutions meeting the criteria in *[section (81) of]* this rule which are established for the treatment of sick and injured persons through spiritual means and are operated under the authority of organizations which are recognized under Medicare (Title I of Public Law 89-97).

*[(83)]***(118)** Sound natural teeth. Teeth and/or tissue that is viable, functional, and free of disease. A sound natural tooth has no decay, fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.

(119) Specialty care physician/specialist. A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

*[(84)]***(120)** Specialty *[drugs]* **medications**. High cost drugs that are primarily self-injectible but sometimes oral medications.

*[(85)]***(121)** State. Missouri.

(122) Step therapy. Designed to encourage use of therapeutically-equivalent, lower-cost alternatives before stepping up to more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

*[(86)]***(123)** Subrogation. The substitution of one **(1)** "party" for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan to stand in the place of the participant and recover the money directly from the other insurer.

*[(87)]***(124)** Subscriber. The employee or member who elects coverage under the plan.

(125) Subscriber only participation. Participation of a subscriber without participation of the subscriber's dependents, whether or not the subscriber has dependents.

(126) Surgery. Any operative or invasive diagnostic procedure performed in the treatment of an injury or illness by an instrument or cutting procedure through any natural body opening or incision.

(127) Surgery center (ambulatory). A hospital based, sponsored, or independently-owned facility that performs surgery.

*[(88)]***(128)** Survivor. A member who meets the requirements of **subsection** 22 CSR 10-2.020(5)(A).

*[(89)]***(129)** Unemancipated child(ren). A natural child(ren), a legally adopted child(ren) or a child(ren) placed for adoption, and a dependent disabled child(ren) over twenty-five (25) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:

(A) Stepchild(ren);

(B) Foster child(ren) for whom the employee is responsible for health care;

(C) Grandchild(ren) for whom the employee has legal custody and is responsible for providing health care; **and**

(D) Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator.

1. Except for a disabled child(ren) as described in section *[(58)]***(87)** of this rule, an unemancipated child(ren) is eligible from birth to the end of the month in which s/he is emancipated, as defined here, or attains age twenty-five (25) (see **paragraph** 22 CSR 10-2.020(3)(D)2. for continuing coverage on a handicapped child(ren) beyond age twenty-five (25)); and

(E) Stepchild(ren) who are not domiciled with the employee, provided the natural parent who is legally responsible for providing coverage is also covered as a dependent under the plan.

(130) Urgent care. Medically necessary services in order to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician office but not severe enough to require treatment in a hospital emergency department.

(131) Urgent care centers. Medical facilities that provide extended or twenty-four (24)-hour service to treat minor conditions at a lower cost than emergency room treatment.

*[(90)]***(132)** Usual, Customary, and Reasonable charge.

(A) Usual. The fee a physician most frequently charges the majority of his/her patients for the same or similar services.

(B) Customary. The range of fees charged in a geographic area by physicians of comparable skills and qualifications for the same performance of similar service.

(C) Reasonable. The flexibility to take into account any unusual clinical circumstances involved in performing a particular service.

(D) A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the doctors for ninety percent (90%) of the procedures reported.

*[(91)]***(133)** Utilization review. Evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities on a prospective, concurrent, or retrospective basis.

*[(92)]***(134)** Vested subscriber. A member who meets the requirements of **subsection** 22 CSR 10-2.020(5)(B).

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.020 Subscriber Agreement and General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (1)–(3) and (5)–(8).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the Subscriber Agreement and General Membership Provisions of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be effective immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) The participant's initial application, any subsequently accepted modifications to such application, **the handbook,** and the plan document as adopted by the board along with duly executed amendments shall comprise the subscriber agreement between the participant and the Missouri Consolidated Health Care Plan (MCHCP). Any *[associated administrative guidelines]* **other written materials** interpret**ing** the subscriber agreement for the benefit of members and administrators *[but]* are not a part of the subscriber agreement.

(A) By applying for coverage under the MCHCP**,** a participant agrees that—

1. The employer may deduct the cost of the premium for the employee's plan from the employee's paychecks;

2. Individual and family deductibles, if appropriate, will be applied; and

3. Any individual eligible as an employee shall not be covered as a dependent unless the employee is on an approved leave of absence.

(2) The effective date of participation shall be determined, subject to the effective date provision in subsection (2)(C), as follows:

(A) Employee Participation.

1. If application by an employee is made on or before the date of eligibility, participation shall become effective on such date of eligibility;

2. If application by an employee is made within thirty-one (31) days after the date of eligibility, participation may become effective on the date of eligibility or the first day of the calendar month coinciding with or following the date *[of]* **the** application **is received**, except that participation shall be retroactive to the beginning of the month for employees rehired during the month following the month participation would have terminated; and

3. Not limiting or excluding any of the other provisions, if application is not made within thirty-one (31) days of the employee's date of eligibility, they may apply for coverage only if *[a life event*

occurs. Life events include: marriage, birth, adoption, death, divorce, legal separation, job loss or failure to elect continuation of coverage. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify the plan administrator of the life event;] **one (1) of the following occurs:**

A. Occurrence of a life event which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify the plan administrator of the life event;

B. Loss of a spouse's employer-sponsored group coverage when the employee originally waived coverage through the plan. Application must be made within sixty (60) days of the time—

(I) The employee no longer qualifies for coverage under spouse's plan;

(II) The spouse's employment terminates or he/she is no longer eligible for coverage under employer's plan;

(III) The spouse's employer-sponsored medical, dental, and/or vision plan terminates;

(IV) All employer contributions toward the spouse's plan cease; or

(V) The employee's Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends; or

C. Loss of eligibility for Medicaid, in which case application for coverage through the plan must be made within sixty (60) days of loss;

(B) Dependent Coverage. Dependent participation cannot precede the subscriber's participation **except when coverage is added as a life event with birth of a child or adoption of a child at birth. The effective date for a child is the date of birth. The subscriber and/or dependent's effective date is the first day of the calendar month coinciding with or following the date of the application**. Application for participants must be made in accordance with the following provisions. Effective dates for all dependent coverage is wholly dependent upon *[paragraph (2)(B)1.]*—

1. Proof of eligibility documentation is required for all dependents. The plan reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by the plan administrator, coverage for the applicable dependent will either be terminated or will never take effect.

A. For the addition of dependents: Required documentation should accompany the application for coverage**, except when adding a newborn**. Failure to provide acceptable documentation with the application will result in the dependent not having coverage until such proof is received, subject to the *[deadline noted in part (2)(B)1.A.(I).]* **following:**

(I) If proof of eligibility is not received with the application, such proof will be requested by letter sent to the subscriber. Documentation shall be received no later than thirty (30) days from the date of the letter requesting such proof. Failure to provide the required documentation in a timely manner will result in the dependent being ineligible for coverage until the next open enrollment period unless a life event occurs*[.]***; and**

(II) Coverage is provided for a newborn of a member from the moment of birth. However, coverage will not continue past the first thirty-one (31) days unless required documentation is received;

2. Documentation is also required when a subscriber attempts to terminate a dependent's coverage in the case of divorce or death*[.]***;**

3. Acceptable forms of proof of eligibility are included in the following chart:

Circumstance	Documentation
Birth of dependent(s)	• Birth certificate; or • Hospital certificate
Addition of step-child(ren)	• Marriage license to biological parent of child(ren); and • Birth or Hospital certificate for child(ren) that names the subscriber's spouse as a parent
Addition of foster child(ren)	• Placement papers in subscriber's care
Adoption of dependent(s)	• Adoption papers; or • Placement papers
Legal guardianship of dependent(s)	• Court-documented guardianship papers (Power of Attorney is not acceptable)
Newborn of covered dependent	• *[Birth certificate for subscriber's child(ren); and* • *Birth certificate for subscriber's grandchild(ren)]* **Birth certificate for newborn listing covered dependent as parent with baby's name and birth date**
Marriage	• Marriage license; • Marriage certificate; or • Newspaper notice of the wedding
Divorce	• Final divorce decree; or • Notarized letter from spouse stating he/she is agreeable to termination of coverage pending divorce
Death	• Death certificate

4. For family coverage, once a subscriber is participating with respect to dependents, newly acquired dependents are automatically covered on their effective dates as long as the plan administrator is notified within thirty-one (31) days of the person becoming a dependent. First eligible dependents must be added within thirty-one (31) days of such qualifying event. The employee is required to notify the plan administrator on the appropriate form of the dependent's name, date of birth, eligibility date**,** and Social Security number, if available. Claims will not be processed until the required information is provided*[.]***;**

5. If an employee makes concurrent application for dependent participation on or before the date of eligibility or within thirty-one (31) days thereafter, participation for dependent will become effective on the date the employee's participation becomes effective;

6. When an employee participating in the plan first becomes eligible with respect to a dependent child(ren), coverage may become effective on the eligibility date or the first day of the month coinciding with or following the date of eligibility if application is made within thirty-one (31) days of the date of eligibility and provided any required contribution for the period is made; **and**

[7. Unless required under federal guidelines—

A. An emancipated dependent who regains his/her dependent status is immediately eligible for coverage if an application is submitted within thirty-one (31) days of regaining dependent status; and

B. An eligible dependent that is covered under a spouse's health plan who loses eligibility under the criteria stipulated for dependent status under the spouse's health plan is not eligible for coverage until the next open enrollment period. (Note: Subparagraphs (2)(B)7.A. and B. do not include dependents of retirees or long-term disability members covered under the plan); and]

*[8.]***7.** Survivors, retirees, vested subscribers**,** and long-term disability subscribers may only add dependents to their coverage when the dependent is first eligible for coverage**, except when a dependent's employer-sponsored coverage ends due to one (1) of the following:**

A. Termination of employment;

B. Retirement; and

C. Termination of group coverage by the employer.

Coverage must have been in place for twelve (12) months immediately prior to the loss, and coverage must be requested within sixty (60) days from the termination date of the previous coverage;

(C) Effective Date *[Proviso]* **Provision**. The effective date of coverage is the first of the month coinciding with or following *[your]* **the** eligibility date and the date the form is received by the plan. The effective date of coverage cannot be prior to the date of receipt of the enrollment form by the plan. The effective date for dependent coverage is wholly dependent upon the appropriate proof of eligibility documentation being timely received by the plan (see (2)(B)1.);

[(D) Application for dependent coverage may be made at other times of the year when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's: 1) employment is terminated or is no longer eligible for coverage under his/her employer's plan, or 2) employer-sponsored medical plan is terminated. With respect to dependent child(ren) coverage, application may also be made at other times of the year when the member receives a court order stating s/he is responsible for providing medical coverage for the dependent child(ren) or when the dependent loses Medicaid coverage. Dependents added under any of these exceptions must supply verification from the previous insurance carrier or the member's employer that they have lost coverage and the effective date of termination. Coverage must also be requested within sixty (60) days from the termination date of the previous coverage. Application must be made within sixty (60) days of the court order. (Note: This section does not include dependents of retirees, survivors, vested subscribers, or long-term disability subscribers covered under the plan);

(E) When an employee experiences applicable life events, eligibility will be administered according to Health Insurance Portability and Accountability Act (HIPAA) guidelines.]

(D) Application for dependent coverage may be made within sixty (60) days when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's—

1. Employer-sponsored medical, dental, or vision plan terminates or coverage by the employer is no longer offered;

2. The employer contributions toward the premiums cease;

3. COBRA coverage ceases; or

4. A dependent no longer qualifies due to age;

(E) Application may be made for dependent coverage within sixty (60) days of the event—

1. A Qualified Medical Child Support Order is received; or

2. A dependent no longer qualifies for Medicaid; or

(F) Application may be made for dependent coverage within thirty-one (31) days of an emancipated dependent regaining dependent status.

(3) Termination of participation shall occur on the last day of the calendar month coinciding with or following the happening of any of the following events, whichever shall occur first:

(A) Written **or phone** request by the employee;

(D) Termination of Eligibility for Participation.

1. With respect to employees, termination of participation shall occur upon termination of employment in a position covered by the MCHCP, except as specified in sections (4) and (5).

2. With respect to dependents, termination of participation shall occur upon ceasing to be a dependent as defined in this rule or upon failure to provide the plan with acceptable proof of eligibility with the following exception: unemancipated mentally *[retarded]* and/or physically handicapped children will continue to be eligible beyond age twenty-five (25) during the continuance of a permanent disability provided documentation satisfactory to the plan administrator is furnished by a physician prior to the dependent's twenty-fifth birthday, and as requested at the discretion of the plan administrator.

3. Termination of employee's participation shall terminate the participation of dependents, except as specified in section (5).

(5) Continuation of Coverage.

(A) Dependents. Termination of an active employee's participation by reason of death shall not terminate participation with respect to the surviving spouse and/or dependent children if*[—]*

*[1. T]***t**he active employee was vested and eligible for a future retirement benefit*[; or]* **and**

[2. Your] eligible dependents meet one (1) of the following conditions:

*[A.]***1.** They have had coverage through MCHCP since the effective date of the last open enrollment period;

*[B.]***2.** They have had other health insurance for the six (6) months immediately prior to *[your]* **the employee's** death—proof of insurance is required; or

*[C.]***3.** They have had coverage through MCHCP since they were first eligible.

(C) Coverage at Termination. A former employee may participate in the plan if s/he terminates employment before retirement provided s/he is a vested employee. This means s/he will be eligible for a benefit from the Missouri State Employees' Retirement System, the Public School Retirement System, the retirement system of a participating public entity**,** or the *[Highway Retirement System]* **Missouri Department of Transportation and Highway Patrol Employees' Retirement System** when s/he reaches retirement age. Coverage may also be continued by a member of the general assembly, a state official holding a statewide elective office, or an employee employed by an elected state official or member of the general assembly whose employment is terminated because the state official or member of the general assembly ceases to hold elective office. The election to participate must be made within thirty-one (31) days from the last day of the month in which employment terminated. The member must pay the full cost of coverage. However, s/he will not later be eligible if s/he discontinues coverage at some future time.

(D) Leave of Absence. An employee on approved leave of absence may elect to retain eligibility to participate in the plan by paying the required contributions. The employing department must officially notify the plan administrator of the leave of absence and any extension of the leave of absence by submitting the required form. Any employee on an approved leave of absence who was a member of the Missouri Consolidated Health Care Plan when the approved leave began, but who subsequently terminated participation in the Missouri Consolidated Health Care Plan while on leave, may recommence his/her coverage in the plan at the same level (employee only*[,]* or employee and dependents) upon returning to employment directly from the leave*[, but they will be subject to preexisting limitations, when applicable. Preexisting limitations under this provision will not apply to health maintenance organization (HMO) or point-of-service (POS) members]*. However, eligibility is terminated for those members receiving a military leave of absence, as specified in subsection (3)(C). Coverage may be reinstated upon return from military leave *[without proof of insurability or preexisting conditions]*. However, the former member must complete an enrollment form. Coverage under this provision is effective on the first of the month coinciding with or following the employee's return to work. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date and timely requests reinstatement of coverage.

(F) Workers' Compensation. Any person who is receiving, or is entitled to receive, Workers' Compensation benefits as a result of an injury or accident sustained in employment and who was a member of the plan at the time of becoming disabled may continue his/her

coverage in the plan at the same level of participation *[(employee only or employee and dependents)]* **(subscriber only or subscriber and dependents)** by paying the required contributions, if the disability occurred in the employment through which the employee qualifies for membership in the plan. Any person receiving, or entitled to receive, Workers' Compensation benefits who was a member of the plan at the time of becoming disabled as a result of an injury or accident sustained in employment through which the person qualified for membership in the plan, but who subsequently terminated participation in the plan, may recommence his/her coverage in the plan at the same level *[(employee only, or employee and dependents)]* **(subscriber only or subscriber and dependents)** upon returning to employment*[, without proving insurability]*.

(G) Reinstatement After Dismissal. If an employee is approved to return to work after being terminated as a result of legal or administrative action available as a recourse through his/her employer, s/he will be allowed to reinstate his/her medical benefit retroactively to the date of dismissal. If the employee is reinstated with back pay, s/he will be responsible for paying any contribution normally made for either his/her coverage or his/her covered dependents. *[No preexisting condition limitation will apply.]* If the employee is reinstated without back pay, s/he will be considered to have been on a leave of absence. Consequently, the employee will be responsible for making any required contribution toward the cost of his/her medical benefits. If the employee does not purchase coverage for the period between termination and reinstatement, s/he may regain the same level of coverage s/he had prior to termination. *[If the employee participates in a preferred provider organization (PPO) plan, the preexisting condition limitation will apply if coverage lapsed more than sixty-three (63) days. This does not apply if the employee participates in an HMO or POS.]*

(6) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) In accordance with the COBRA, eligible employees and their dependents may continue their medical coverage after the employee's termination date.

1. Employees terminating for reasons other than gross misconduct **or receiving a reduction in the number of hours of employment** may continue coverage for themselves and their covered dependents for eighteen (18) months at their own expense.

2. A surviving spouse and dependents, not normally eligible for continued coverage, may elect coverage for up to thirty-six (36) months at their own expense.

3. A divorced spouse may continue coverage at his/her own expense for up to thirty-six (36) months if the plan administrator is notified within sixty (60) days from the date coverage would terminate.

4. Dependent spouse and/or child(ren) may continue coverage up to thirty-six (36) months if the covered employee retires and the dependent spouse/child(ren) has not been covered by the plan for two (2) years.

5. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense if the plan administrator is notified within sixty (60) days of the loss of the dependent's eligibility.

6. Employees who are disabled at termination or become disabled during the first sixty (60) days of coverage may continue coverage for up to twenty-nine (29) months.

7. Premiums for continued coverage will be one hundred two percent (102%) of the health plan rate, one hundred fifty percent (150%) if disabled. Once coverage is terminated under the COBRA provision**,** it cannot be reinstated.

8. All operations under the COBRA provision will be applied in accordance with federal regulations.

(7) Missouri State Law COBRA Wrap-Around Provisions—Missouri law provides that if *[you lose your]* **a member loses** group health insurance coverage because of a divorce, legal separation**,** or the death of *[your]* **a** spouse**,** *[you]* **the member** may continue coverage until age sixty-five (65) if: a) *[You]* **The member** continue**s** and maintain**s** coverage under the thirty-six (36)-month provision of COBRA; and b) *[You are]* **The member is** at least fifty-five (55) years old when *[your]* COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions and will have to pay all of the application premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium. The above Cancellation of Continuation Coverage also applies to COBRA wrap-around continuation.

(8) *[Medicare—Participants eligible for Medicare who are not eligible for this plan as their primary plan, shall be eligible for benefits no less than those benefits for participants not eligible for Medicare. For such participants who elect to continue their coverage, benefits of this plan shall be coordinated with Medicare benefits on the then standard coordination of benefits basis to provide up to one hundred percent (100%) reimbursement for covered charges.*

(A) If a participant eligible for Medicare who is not eligible for this plan as the primary plan is not covered by Medicare, an estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim submitted basis so that if, for a given claim, Medicare reimbursement was for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims;

(B) If a participant eligible for Medicare Part D enrolls in a Medicare Part D plan in addition to coverage under this plan, such participant's coverage may be terminated under this plan in order for the plan to avoid liability for filing a false claim under the subsidy reimbursement portion of Medicare Part D; and

(C)] If any retired participants or long-term disability recipients, their eligible dependents**,** or surviving dependents eligible for coverage elect not to be continuously covered from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.045 Plan Utilization Review Policy. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri

Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be effective immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program consists of four (4) parts, as described in the following:

(A) Precertification—The medical necessity of a non-emergency hospital admission, specified procedures as documented in the claims administrator's guidelines, and/or skilled nursing services provided on an inpatient basis must be prior authorized by the appropriate *[review agency]* **claims administrator**. For emergency hospital admissions, the *[review agency]* **claims administrator** must be notified within forty-eight (48) hours of the admission. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(B) Concurrent Review—The *[review agency]* **claims administrator** will continue to monitor the medical necessity of the admission and approve the continued stay in the hospital. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(C) Large Case Management—Members *[that]* **who** require long-term acute care may be offered the option of receiving the care, if appropriate, in a more cost-effective setting such as a skilled nursing facility or their own home. In some cases**,** this may require coverage for benefits that normally are not covered under the plan. These benefits may be provided through the approval of the claims administrator;

(E) Penalties—Members not complying with subsections (1)(A) and (B) of this rule may be subject to a financial penalty in connection with their covered benefits. *[(Note: The utilization review program will be operated in accordance with the administrative guidelines.)]*

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.050 *[PPO and Co-Pay]* ***Copay Plan*** **Benefit Provisions and Covered Charges**. The Missouri Consolidated Health Care Plan is amending sections (1)–(4).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the Copay Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be effective immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) **Non-network** *[D]***d**eductible amount—per individual for the *[Preferred Provider Organization (PPO)]* **Copay** *[p]***P**lan each calendar year, *[five hundred dollars ($500)]* **six hundred dollars ($600)**, family limit each calendar year, one thousand **two hundred** dollars *[($1,000)]* **($1,200)**.

(2) Coinsurance—non-network coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once out-of-pocket maximum is reached.

(A) Coinsurance is seventy percent (70%) after deductible is met when utilizing non-network providers.

*[(A)]***(B)** The deductible is waived and claims are paid at eighty percent (80%) for the following services: home health care, infusion, durable medical equipment (DME), and audiologists.

*[(B)]***(C)** Claims may also be paid at eighty percent (80%) if *[you]* **the subscriber** requires covered services that are not available through a network provider *[in your area]* **within fifty (50) miles of his/her home**. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

*[(C)]***(D)** Non-network claims—**are paid at** seventy percent (70%) *[of the first four thousand dollars ($4,000)]* **until two thousand four hundred dollars ($2,400) has been met** for an individual, *[or of the first eight thousand dollars ($8,000)]* **four thousand eight hundred dollars ($4,800) has been met** for a family, of covered charges in the calendar year which are subject to coinsurance. **Claims are paid at** *[O]***o**ne hundred percent (100%) of any excess covered charges in the calendar year. *[But see the provision applicable to second opinion, substance abuse, and mental and nervous conditions, chiropractic care, and PPOs.]*

(3) *[Co-payments]* **Copayments**—set charges for the following types of claims so long as network providers are utilized.

[Co-payments are no longer charged for the remainder of the calendar year once out-of-pocket maximum is reached with the exceptions noted under (3)(G).]

(A) Office visit—**primary care:** twenty-five dollars ($25)**; specialist: thirty-five dollars ($35)**.

(C) Inpatient hospitalizations—three hundred dollars ($300) per admission**; one thousand two hundred dollars ($1,200) annual maximum inpatient copayment**.

(D) Maternity—**primary care:** twenty-five dollars ($25) for initial visit**; specialist: thirty-five dollars ($35)**.

(F) Outpatient surgery—*[seventy-five dollars ($75)]* **one hundred dollars ($100)**.

[(G) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: office visits, emergency room visits, hospital admissions, outpatient surgery, claims for services paid at one hundred percent (100%), charges above the Usual, Customary, and Reasonable (UCR) limit, percentage amount coinsurance is reduced as a result of non-compliance with pre-certification, coinsurance amounts related to infertility benefits, and charges above the maximum allowable amount for transplants performed by a non-network provider.]

(G) Emergency room—one hundred dollars ($100) network and non-network.

(H) Urgent care—thirty-five dollars ($35) network and non-network.

(4) Out-of-pocket **non-network** maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year. *[Certain co-payments do not apply to the out-of-pocket maximum as noted under (3)(G).]*

[(A) Network out-of-pocket maximum for individual—two thousand dollars ($2,000);

(B) Network out-of-pocket maximum for family—four thousand dollars ($4,000);]

*[(C)]***(A)** Non-network out-of-pocket maximum for individual—*[four thousand dollars ($4,000);]* **two thousand four hundred dollars ($2,400); and**

*[(D)]***(B)** Non-network out-of-pocket maximum for family—*[eight thousand dollars ($8,000);]* **four thousand eight hundred dollars ($4,800).**

(C) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include: copayments; claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RULE

22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 300 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Deductible amount—Network: per individual each calendar year, three hundred dollars ($300); family limit each calendar year, six hundred dollars ($600). Non-network: per individual each calendar year, six hundred dollars ($600); family limit each calendar year, one thousand two hundred dollars ($1,200).

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once out-of-pocket maximum is reached.

(A) Network claims—are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims may also be paid at ninety percent (90%) if the subscriber requires covered services that are not available through a network provider within fifty (50) miles of his/her home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network out-of-pocket maximum for individual—one thousand two hundred dollars ($1,200).

(B) Network out-of-pocket maximum for family—two thousand four hundred dollars ($2,400).

(C) Non-network out-of-pocket maximum for individual—two thousand four hundred dollars ($2,400).

(D) Non-network out-of-pocket maximum for family—four thousand eight hundred dollars ($4,800).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include: claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(4) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1)–(3) and (5).

PURPOSE: This amendment includes changes to the High Deductible Health Plan Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be effective immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Deductible amount—*[In]* Network: per individual *[for the High Deductible Health Plan (HDHP)]* each calendar year, one thousand two hundred dollars ($1,200)*[,]***;** family limit each calendar year, two thousand four hundred dollars ($2,400). Non-network: per individual *[for the High Deductible Health Plan (HDHP)]* each calendar year, two thousand four hundred dollars ($2,400)*[,]***;** family limit each calendar year, four thousand eight hundred dollars ($4,800).

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once out-of-pocket maximum is reached. *[Coinsurance is twenty percent (20%) after deductible is met when utilizing network providers. Coinsurance is forty percent (40%) after deductible is met when utilizing non-network providers. Claims may also be paid at eighty percent (80%) if you require covered services that are not available through a network provider in your area. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.]*

(A) Network claims—are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims may also be paid at eighty percent (80%) if the subscriber requires covered services that are not available through network provider within fifty (50) miles of his/her home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network out-of-pocket maximum for individual—two thousand four hundred dollars ($2,400)*[;]***.**

(B) Network out-of-pocket maximum for family—four thousand eight hundred dollars ($4,800)*[;]***.**

(C) Non-network out-of-pocket maximum for individual—four thousand eight hundred dollars ($4,800)*[;]***.**

(D) Non-network out-of-pocket maximum for family—nine thousand six hundred dollars ($9,600)*[;]***.**

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(5) *[Prescription costs are applied to the medical plan deductible.]* **Pharmacy benefits are subject to the applicable medical plan deductible and coinsurance.**

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RULE

22 CSR 10-2.054 Medicare Supplement Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Medicare Supplement Plan Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Eligibility—Subscribers and dependents covered in this plan must be enrolled in Medicare, and the subscribers must receive a monthly retirement benefit from either the Missouri State Employees' Retirement System (MOSERS) or from the Public School Retirement System (PSRS), based on years of service. A subscriber may enroll in this plan when first eligible for Medicare.

(2) Available services—The Medicare Supplement Plan covers coinsurance amounts on Medicare Parts A and B eligible benefits after the Medicare deductibles are met.

(A) Inpatient hospital care—covers Medicare Part A coinsurance plus coverage for three hundred sixty-five (365) additional days after Medicare coverage ends;

(B) Medical costs—covers Medicare Part B coinsurance;

(C) Blood—covers the first three (3) pints of blood each year; and

(D) Prescription drug coverage.

(3) Limitations and exclusions—

(A) Charges above Medicare allowed amounts are the member's responsibility; and

(B) Limitations and exclusions follow Medicare guidelines.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1) and (2).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the Medical Plan Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be effective immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Benefit Provisions **Applicable to the HMO, Copay, PPO 300, and HDHP Plans**.

(A) Subject to the plan provisions and limitations and the written application of the employee, the benefits are payable for covered charges incurred by a participant while covered under the *[co-pay or preferred provider organization (PPO)]* plan**s**, provided the deductible requirement, if any, is met.

(D) The total amount of benefits payable for all covered charges incurred *[out-of]***non**-network during an individual's lifetime shall not exceed the lifetime maximum.

[(E) If both husband and wife are participating separately as employees under this plan, the family deductible and benefit features shall nevertheless apply to the benefit of the family unit.]

(2) Covered Charges **Applicable to the HMO, Copay, PPO 300, and HDHP Plans**.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.060 PPO *300 Plan*, HDHP, *[and Co-Pay]* *Copay, and HMO* Plan Limitations. The Missouri Consolidated Health Care Plan is amending sections (2) and (5); adding new sections (8), (17), (40), (44), and (48)–(51); renumbering and amending sections (8)–(37), (39)–(41), and (43)–(52); and removing sections (38) and (42).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the PPO 300 Plan, HDHP, Copay Plan, and HMO Limitations for members of the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be effective immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010*

(2) If applicable, all hospitalizations, outpatient treatment for chemical dependency**,** or mental and nervous disorder that *[are not precertified]* **do not receive prior authorization** as described in 22 CSR 10-2.045, reimbursement will be reduced by ten percent (10%) of reasonable and customary charges.

(5) Alternative therapies—including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, biofeedback, and other forms of alternative therapy **with the exception of aquatic therapy performed by a physical therapist**.

(8) Breast augmentation mammoplasty—not covered unless associated with breast surgery following a medically necessary mastectomy incurred secondary to active disease.

*[(8)]***(9)** Care received without charge.

*[(9)]***(10)** Comfort and convenience items.

*[(10)]***(11)** Cosmetic, plastic, reconstructive**,** or restorative surgery—unless medically necessary to repair a functional disorder caused by disease, injury**,** or congenital defect or abnormality (for a participant under the age of nineteen (19)) or to restore symmetry following a mastectomy.

*[(11)]***(12)** Custodial or domiciliary care—includes services and supplies that assist members in the activities of daily living like walking, getting in and out of bed, bathing, dressing, feeding**,** and using the toilet; preparation of special diets and supervision of medication that is usually self-administered.

*[(12)]***(13)** Dental—treatment must be initiated within sixty (60) days of accident. Limited to treatment of accidental injury to sound natural teeth. Oral surgery is covered only when medically necessary as a direct result from injury, tumors**,** or cysts. Dental care, including oral surgery, as a result of poor dental hygiene is not covered. Extractions of bony or partial bony impactions are excluded.

*[(13)]***(14)** Durable medical equipment and disposable supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings**,** and support hose. Over-the-counter medications and supplies. Prescription compression stockings are limited to two (2) pairs of four (4) individual stockings per plan year.

*[(14)]***(15)** Educational or psychological testing—not covered unless part of a treatment program for covered services.

*[(15)]***(16)** Examinations requested by a third party.

(17) Excessive charges—any otherwise eligible expenses that exceed the maximum allowance or benefit limit.

*[(16)]***(18)** Exercise equipment.

*[(17)]***(19)** Experimental services or investigational services—experimental or investigational services, procedures, supplies**,** or drugs as determined by the claims administrator are not covered, except clinical trials for cancer treatment as specified by law.

*[(18)]***(20)** Eye glasses and contact lenses—charges incurred in connection with the fitting of eye glasses or contact lenses except for initial placement immediately following cataract surgery.

*[(19)]***(21)** Eye services—health services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK**,** and other refractive eye surgery.

*[(20)]***(22)** Services obtained at a government facility—not covered if care is provided without charge.

*[(21)]***(23)** Hair analysis, wigs**,** and hair transplants—services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also, hairstyling wigs, hairpieces**,** and hair prostheses, including those ordered by a participating provider**,** are not covered. Such items and services are not covered except for members ages eighteen (18) and under with alopecia as specified by law. Subject to two hundred dollar ($200) annual maximum and three thousand two hundred dollar ($3,200) lifetime maximum.

*[(22)]***(24)** Health and athletic club membership—including costs of enrollment.

*[(23)]***(25)** Immunizations requested by third party or for travel.

*[(24)]***(26)** Infertility—*[not covered.]* **Infertility treatments are limited to in-vivo (intrauterine, intracervical, intravaginal fertilization).** Those health services and associated expenses for the treatment of infertility **are not covered,** including reversal of voluntary sterilization, intracytoplasmic sperm injection (ICSI), *in vitro* fertilization, gamete intrafallopian transfer (GIFT)**,** and zygote intrafallopian transfer (ZIFT) procedures; embryo transport; donor sperm and related cost for collection; no cryopreservation of sperm or eggs; and non-medically necessary amniocentesis.

*[(25)]***(27)** Level of care, if greater than is needed for the treatment of the illness or injury.

*[(26)]***(28)** Medical care and supplies—not to the extent that they are payable under—

(A) A plan or program operated by a national government or one **(1)** of its agencies; or

(B) Any state's cash sickness or similar law including any group insurance policy approved under such law.

*[(27)]***(29)** Medical service performed by a family member—including a person who ordinarily resides in *[your]* **the subscriber's** household or is related to the participant, such as a spouse, parent, child, sibling**,** or brother/sister-in-law.

*[(28)]***(30)** Military service connected injury or illness.

*[(29)]***(31)** Non-network providers—subject to deductible and non-network coinsurance.

*[(30)]***(32)** Not medically necessary services—with the exception of preventive services.

*[(31)]***(33)** Obesity—medical and surgical intervention is not covered, unless the member meets the definition of severe **morbid** obesity as defined in 22 CSR 10-2.010 *[and such severe obesity has persisted for at least five (5) years]* **and satisfies all requirements described in the plan**. Bariatric surgery will only be covered when prior authorization is received from the medical plan. *[Please see the current State Member Handbook for further limitations regarding bariatric surgery.]*

(A) Bariatric surgery additional qualifying criteria—

1. Presence of severe morbid obesity that has persisted for at least five (5) years defined as body mass index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled comorbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions approved by the plan based on clinical review;

2. Member must be eighteen (18) years of age or older;

3. Documented evidence of at least two (2) failed attempts at weight loss each with a minimum duration of at least six (6) months with the member achieving at least a ten percent (10%) weight loss and meeting the following additional criteria: one (1) attempt must be in a physician-supervised weight loss program and fully documented in the physician's record; the program must use a multidisciplinary approach including dietician consultation, low-calorie diet, increased physical activity, and behavioral modification; nationally recognized program such as Jenny Craig or Weight Watchers (This does not include self-directed low-calorie diets such as the Atkins Diet or South Beach Diet.); and the most recent attempt must have been within the twelve (12)-month period prior to the requested surgery;

4. Documented evidence the member is on a nutrition and exercise program immediately prior to the surgery request;

5. Evidence the member and the attending physician have a life-long plan for compliance with lifestyle modification requirements;

6. Documentation the member has completed a psychological evaluation and, if appropriate, behavior modification and should be free of major psychiatric diagnosis or a current behavior which would significantly reduce long-term effectiveness of the proposed treatment; and

7. Procedure must be performed at a Centers of Excellence (COE) facility for Bariatric Surgery as determined by the Centers for Medicare and Medicaid Services.

(B) Network services are limited to one (1) operative procedure for the treatment of obesity per lifetime. Non-network obesity services are not covered.

(C) Revisions and corrections of bariatric procedures are covered only when the revision or correction is used to treat life-threatening complications (e.g., wound infection, abscess, dehiscence, gastric leaking, and embolism). Coverage is limited to the following bariatric procedures: Roux-en-Y Gastric Bypass—open and laparoscopic (RYGBP), Laparoscopic Adjustable Gastric Banding (LAGB), and Open and Laparoscopic Biliopancreatic Diversion with Duodenal Switch (BPD/DS).

*[(32)]***(34)** Orthognathic surgery.

*[(33)]***(35)** Orthoptics.

*[(34)]***(36)** Other charges—no coverage for charges that would not be incurred if *[you were]* **the subscriber was** not covered. Charges for which *[you]* **the subscriber** or *[your]* **his/her** dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted. Charges made in *[your]* **the subscriber's** name but which are actually due to the injury or illness of a different person not covered by the plan. **Miscellaneous service charges—telephone consultations, charges for failure to keep scheduled appointment (unless the scheduled appointment was for a mental health service), or any late payment charge.**

*[(35)]***(37)** Over-the-counter medications—except for insulin through the pharmacy benefit.

*[(36)]***(38)** Over-the-counter supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings**,** and support hose.

*[(37)]***(39)** Physical fitness.

(40) Physical, speech, and occupational therapy—health services and associated expenses for development delay. Treatment for disorders relating to delays in learning, motor skills, and communications.

[(38) Pre-existing conditions—not covered for charges associated with pre-existing conditions.]

*[(39)]***(41)** Private duty nursing.

*[(40)]***(42)** Prosthetic repair or replacement—not covered unless due to normal wear and tear, if there is a change in medical condition, if growth related**,** or medically necessary.

*[(41)]***(43)** Services not specifically included as benefits.

(44) Services rendered after termination of coverage—those services otherwise covered under the agreement, but rendered after the date coverage under the agreement terminates, including services for medical conditions arising prior to the date individual coverage under the agreement terminates.

[(42) Smoking cessation—patches and gum are not covered. There is a limited benefit available under the pharmacy benefit.]

*[(43)]***(45)** Stimulators (for bone growth)—not covered unless authorized by claims administrator.

*[(44)]***(46)** Surrogacy—pregnancy coverage is limited to plan member.

*[(45)]***(47)** Temporo-Mandibular Joint Syndrome (TMJ).

(48) Third-party examinations.

(49) Tobacco cessation—patches and gum are not covered. There is a limited benefit available under the pharmacy benefit.

(50) Transplants—double listing—payment only for one (1) evaluation up to time of actual transplant.

(51) Transplants—travel expense—requires authorization from medical plan. Limited to ten thousand dollar ($10,000) maximum per transplant when accessing network services.

*[(46)]***(52)** Transsexual surgery—health services and associated expenses in the transformation operations regardless of any diagnosis or gender role disorientation or psychosexual orientation or any treatment or studies related to sex transformation. Also excludes hormonal support for sex transformation.

*[(47)]***(53)** Travel expenses—not covered unless authorized by claims administrator.

*[(48)]***(54)** Trimming of nails, corns**,** or calluses—not covered except for persons being treated for diabetes, peripheral vascular disease**,** or blindness.

*[(49)]***(55)** Usual, Customary**,** and Reasonable (UCR)—charges exceeding UCR are not covered, as applicable to the non-network benefit.

*[(50)]***(56)** Vitamins and nutrients—limited to prenatal agents for pregnancy, therapeutic agents for specific deficiencies and conditions**,** and hematopoietic agents through the pharmacy benefit.

*[(51)]***(57)** War or insurrection—liability to provide services limited in the event of a major disaster, epidemic, riot**,** or other circumstances beyond the control of the plan.

*[(52)]***(58)** Workers' compensation—*[charges for services and treatment of an injury incurred during the course of employment and covered by Workers' Compensation, occupational disease law or similar laws, including all charges to be covered by any associated settlement agreement]* **charges for services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other legislation of similar program**.

AUTHORITY: section 103.059, RSMo 2000 ***and section 103.080.3, RSMo Supp. 2008****. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.064 HMO *[and POS]* **Summary of Medical Benefits**. The Missouri Consolidated Health Care Plan is amending sections (1) and (2).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to HMO Summary of Medical Benefits for members of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be effective immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Co*[-]*payments—set charges for the following types of claims so long as network providers are utilized.

(A) Office visit—**primary care:** twenty-five dollars ($25)**; specialist: thirty-five dollars ($35)**.

(C) Inpatient hospitalizations—three hundred dollars ($300) per admission**; one thousand two hundred dollars ($1,200) annual maximum inpatient copayment**.

(D) Maternity—**primary care:** twenty-five dollars ($25) for initial visit**; specialist: thirty-five dollars ($35)**.

(F) Outpatient surgery—*[seventy-five dollars ($75)]* **one hundred dollars ($100)**.

(G) Emergency room—one hundred dollars ($100).

(H) Urgent care—thirty-five dollars ($35).

(2) Out-of-pocket maximum—Limited to no more than fifty percent (50%) of the cost of providing a single service. Co*[-]*payments are limited to no more than twenty percent (20%) of the cost of providing basic health care services for the total benefit period and may not exceed two hundred percent (200%) of the total annual premium. **The total annual premium is any amount paid by, or on behalf of, the member.**

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RESCISSION

22 CSR 10-2.067 HMO and POS Limitations. This rule established the limitations and exclusions of the Missouri Consolidated Health Care Plan HMO and/or POS Plan.

PURPOSE: This rule is being rescinded because the limitations have been incorporated into another rule.

EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this rescission is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be effective immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rescission complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed rescission covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RULE

22 CSR 10-2.090 Pharmacy Benefit Summary

PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions of the pharmacy benefit for the HMO, Copay, PPO 300, and Medicare Supplement Plans of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility, beginning with the first day of coverage for the new plan year. It is imperative that this rule be effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) The pharmacy benefit provides coverage for prescription drugs, as described in the following:

(A) Medications.

1. Network:

A. Generic: Eight dollar ($8) copayment for up to a thirty (30)-day supply for generic drug on the formulary;

B. Formulary brand: Thirty-five dollar ($35) copayment for up to a thirty (30)-day supply for brand drug on the formulary;

C. Non-formulary: Fifty-five dollar ($55) copayment for up to a thirty (30)-day supply for non-formulary drug;

D. Prescriptions filled with a formulary brand drug when there is a Food and Drug Administration (FDA)-approved generic will be subject to the generic copayment amount in addition to paying the difference between the cost of the generic and the formulary brand drug;

E. Mail order program—

(I) Prescriptions may be filled through the mail order program and the member will receive up to a ninety (90)-day supply for two and one-half (2 ½) regular copayments.

(II) Specialty drugs covered only through network mail order for up to thirty (30) days. Copayments:

(a) Generic: six dollars and sixty-seven cents ($6.67);

(b) Formulary brand: twenty-nine dollars and seventeen cents ($29.17); and

(c) Non-formulary: forty-five dollars and eighty-three cents ($45.83).

2. Non-network pharmacies—If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable copayment. All such claims must be filed within twelve (12) months of the incurred expense.

3. Retail prescription drugs—Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.

(2) If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug rather than the copayment.

(3) Retail and mail order coverage includes the following (except for specialty drugs):

(A) Diabetic supplies, including—

1. Insulin;
2. Syringes;
3. Test strips;
4. Lancets; and
5. Glucometers;

(B) Prescribed vitamins, excluding those vitamins that may be purchased over-the-counter;

(C) Prescribed self-injectables;

(D) Oral chemotherapy agents;

(E) Hematopoietic stimulants;

(F) Growth hormones with prior authorization;

(G) Infertility drugs—subject to fifty percent (50%) member coinsurance; and

(H) Tobacco cessation prescriptions—subject to formulary restrictions and limited to five-hundred dollar ($500) annual benefit.

(4) Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. This program involves the member's physician and is only for members

who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a first step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first step drug, the physician may request a prior authorization from the pharmacy plan administrator. If the prior authorization is approved, the member is responsible for the applicable copayment which may be higher than the first step drug. If the requested prior authorization is not approved, then the member is responsible for the full price of the drug.

(A) First Step—

1. Uses primarily generic drugs;
2. Lowest applicable copayment is charged; and
3. First step drugs must be used before the plan will authorize payment for second step drugs.

(B) Second Step—

1. This step applies if the member's treatment plan requires a different medication after attempting the first step medication;
2. Uses primarily brand-name drugs; and
3. Typically, a higher copayment amount is applicable.

(5) Prior Authorization—Certain medications are subject to prior authorization. Network pharmacies will notify the member if prior authorization is required. The member or the pharmacy must contact the pharmacy plan administrator before payment will be approved.

(6) Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. Members may request claim forms from the plan or the pharmacy plan administrator. In order to file a claim, members must—

(A) Complete the claim form; and

(B) Attach a prescription receipt or label with the claim form. Patient history printouts from the pharmacy are acceptable but must be signed by the pharmacist. Cash register receipts are not acceptable for any prescriptions, except diabetic supplies. If attaching a receipt or label, the receipt or label shall include—

1. Pharmacy name and address;
2. Patient's name;
3. Price;
4. Date filled;
5. Drug name, strength, and national drug code (NDC);
6. Prescription number;
7. Quantity; and
8. Days supply.

(7) Formulary—The formulary does not change during a calendar year, unless—

(A) A generic drug becomes available to replace the brand-name drug. If this occurs, the generic copayment applies; or

(B) A drug becomes available over-the-counter. If this occurs, then the drug is no longer covered under the pharmacy benefit; and

(C) A drug is determined to have a safety issue.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. Emergency rescission filed Dec. 21, 2006, effective Jan. 1, 2007, expired June 29, 2007. Rescinded: Filed Dec. 21, 2006, effective June 30, 2007. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.010 Definitions. The Missouri Consolidated Health Care Plan is amending section (1) and breaking it into new sections and adding several new sections.

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the Definitions of the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be effective immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

[(1) When used in this chapter's rules or the public entity member handbook, these words and phrases have the meaning—]

*[(A)]***(1)** Accident*[—An unexpected happening resulting in an injury which is not due to any fault or misconduct on the part of the person injured;]***. An unforeseen and unavoidable event resulting in an injury which is not due to any fault or misconduct on the part of the person injured.**

[(B) Actively at work—You are considered actively at work when performing in the customary manner all of the regular duties of your occupation with the employer either at one (1) of the employer's regular places of business or at some location which the employer's business requires you to travel to perform your regular duties or other duties assigned by your employer. You are also considered to be actively at work on each day of a regular paid vacation or nonworking day on which you are not totally disabled, but only if you are performing in the customary manner all of the regular duties of your occupation with the employer on the immediately preceding regularly scheduled workday;]

(2) Administrative appeal. A written request submitted by or on behalf of a member involving plan-related administrative issues such as eligibility, effective dates of coverage, plan changes, etc.

*[(C)]***(3)**Administrative guidelines*[—The]***. Instructive** interpretation of the plan document *[as approved by the plan administrator,]* developed for administration of the plan. The administrative guidelines may be changed upon approval of the executive director or his/her designee. Benefits provided shall be those in effect at the time services are rendered*[;]***.**

[(D) Automatic reinstatement maximum—The maximum annual amount that can be reinstated to an individual's lifetime benefit;

(E) Benefit year—The twelve (12)-month period beginning January 1 and ending December 31;]

(4) Adverse determination. When the claims administrator reviews an admission, availability of care, continued stay, or other health care service and decides that it is not medically necessary, appropriate, or effective. Therefore, payment for the requested service is denied, reduced, or terminated.

(5) Allowable expense. Charges for services rendered or supplies furnished by a health plan that would qualify as covered expenses and for which the program pays in whole or in part, subject to any deductible, coinsurance, or table of allowance included in the program.

(6) Appeal. A written complaint submitted by or on behalf of a member regarding one (1) of the following:

(A) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or

(B) Claim payment, handling, or reimbursement for pharmacy benefits or health care services.

(7) Benefit period. The three hundred sixty-five (365) days immediately following the first date of like services.

*[(F)]***(8)** Benefits*[—]***.** Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator*[;]***.**

[(G) Care Support Program—A voluntary program that helps manage a chronic condition with outpatient treatment;]

(9) Birthday rule. If both parents have medical coverage, the primary plan for dependent children is the plan of the parent whose birthday occurs first in the calendar year. If birthdays occur on the same day, the parent's coverage that has been in effect longest is primary.

(10) Board. The board of trustees of the Missouri Consolidated Health Care Plan.

(11) Calendar year. The period of time from January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All annual deductibles and benefit maximums accumulate during the calendar year.

(12) Chiropractic services. The examination, diagnosis, adjustment, manipulation, and treatment of malpositioned articulations and structures of the body, directed toward restoring and maintaining the normal neuromuscular and musculoskeletal function and health.

*[(H)]***(13)** Claims administrator*[—]***.** An organization or group responsible for the processing of claims and associated services for the plan's self-insured benefit programs *[and preferred provider organization (PPO);]***, including but not limited to the preferred provider organization (PPO) (also known as the copay plan) and health maintenance organization (HMO) type plans.**

(14) Coinsurance. The shared portion of payment between the plan and the subscriber where each pays a percentage of covered charges.

(15) Comprehensive major medical. A plan that provides for cost sharing to be applied to all covered expenses such as deductible or coinsurance.

(16) Congenital defect. Existing or dating from birth. Acquired through development while in the uterus.

(17) Convenient care clinics (CCCs). Health care clinics located in retail stores, supermarkets, and pharmacies that treat routine family illnesses and provide preventive health care services. They are sometimes referred to as "retail-based clinics" or "walk-in medical clinics." CCCs are usually staffed by nurse practitioners or physician assistants. Some CCCs, however, are staffed by physicians.

(18) Coordination of benefits. Communication, adjustment, and reconciliation procedures between multiple benefit plans covering the same member for purposes of covering services and expenses relating to plan benefits.

(19) Copay plan. A set of benefits similar to a health maintenance organization option.

(20) Copayment. A set dollar amount that the covered individual must pay for specific services.

*[(I)]***(21)** Cosmetic surgery*[—]***.** A procedure performed primarily **for psychological purposes or** to preserve or improve appearance rather than restore the anatomy and/or function of the body which are lost or impaired due to illness or injury*[;]***.**

*[(J)]***(22)** Covered benefits **and charges.** *[—]* A schedule of covered services and charges*[, including chiropractic services, which are]* payable under the plan*[;]***. The benefits covered under each type of plan are outlined in the applicable rule in this chapter.**

*[(K)]***(23)** Custodial care**.** *[—Care designed essentially to assist an individual to meet the activities of daily living; for example, assistance in bathing, supervision of medication which can usually be self-administered and which does not entail or require the continuing attention of trained medical or paramedical personnel;]* **Services and supplies furnished primarily to assist an individual to meet the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a health care provider or that do not entail and require the continuing attention of trained medical or paramedical personnel.**

(24) Date of service. Date medical services are received or performed.

(25) Deductible. The amount of expense the member must pay before the plan begins to pay for covered services and supplies. This amount is not reimbursable by the plan.

*[(L)]***(26)** Dependent-only participation*[—]***.** Participation of certain survivors of *[employees]* **subscribers**. Dependent participation may be further defined to include the deceased *[employee's]* **subscriber's**:

*[1)]***(A)** *[s/]***S**pouse only;

*[2)]***(B)** *[c/]***C**hild(ren) only; or

*[3)]***(C)** *[s/]***S**pouse and child(ren)*[;]***.**

*[(M)]***(27)** Dependents*[—]***.** The lawful spouse of the employee, the employee's unemancipated child(ren), and certain survivors of employees, as provided in the plan document and these rules, for

whom application has been made and has been accepted for participation in the plan*[;]*.

(28) Diagnostic charges. The Usual, Customary, and Reasonable (UCR) charges or the network discounted rate (NDR) for x-ray or laboratory examinations made or ordered by a physician in order to detect a medical condition.

(29) Disposable supplies. Medical supplies that do not withstand prolonged use and are periodically replaced. Includes, but not limited to, colostomy and ureterostomy bags.

(30) Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:
(A) Doctor of medicine;
(B) Doctor of osteopathy;
(C) Podiatrist;
(D) Optometrist;
(E) Chiropractor;
(F) Psychologist;
(G) Doctor of dental surgery; or
(H) Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practice of spiritual healing are well established and recognized.

(31) Durable medical equipment (DME). Equipment able to withstand repeated use for the therapeutic treatment of an active illness or injury. Such equipment is not covered under the plan if it could be useful to a person in the absence of an illness or injury and could be purchased without a physician's prescription.

*[(N)]***(32)** Eligibility date*[—]*. Refer to 22 CSR 10-3.020 for effective date provisions. *[1.]* Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of eligibility as determined by the employer.

*[(O)]***(33)** Emancipated child(ren)*[—]*. A child(ren) who is—
*[1.]***(A)** Employed on a full-time basis;
*[2.]***(B)** Eligible for group health benefits in his/her own behalf;
*[3.]***(C)** Maintaining a residence separate from his/her parents or guardian—except for full-time students in an accredited school or institution of higher learning; or
*[4.]***(D)** Married*[;]*.

(34) Emergency. Any medical condition leading a prudent layperson to seek immediate medical attention. This normally means the sudden onset of a health condition that manifests itself by acute symptoms and severity (including severe pain). Examples of medical emergencies include, but are not limited to:
(A) Conditions placing a person's health in significant jeopardy;
(B) Serious impairment to a bodily function;
(C) Serious dysfunction of any bodily organ or part;
(D) Inadequately controlled pain; or
(E) Situations when the health of a pregnant woman or her unborn child are threatened.

(35) Emergency room. The section of a hospital equipped to furnish emergency care to prevent the death or serious impairment of the covered person.

*[(P)]***(36)** Employee and dependent participation*[—]*. Participation of an employee and the employee's eligible dependents. *[Dependent participation may be further defined to include the participating employee's: 1) spouse only; 2) child(ren) only; or 3) spouse and child(ren).]* Any individual eligible for participation as an employee is not eligible as a dependent, except as noted in 22 CSR 10-3.030(1)(A)*[9.;]***7. Dependent participation may be further defined to include the participating employee's:**
(A) Spouse only;
(B) Child(ren) only; or
(C) Spouse and child(ren).

[(Q) Employee only participation. Participation of an employee without participation of the employee's dependents, whether or not the employee has dependents;]

*[(R)]***(37)** Employees*[—]*. Employees of the participating public entity and present and future retirees from the participating public entity who meet the eligibility requirements as prescribed by the participating public entity*[;]*.

*[(S)]***(38)** Employer*[—]*. The public entity that employs the eligible employee as defined above*[;]*.

*[(T)]***(39)** Executive director*[—]*. The *[administrator]* **chief executive officer** of the Missouri Consolidated Health Care Plan (MCHCP) who *[reports directly to the plan administrator;]* **shall have charge of the offices, records, and employees of the plan, subject to the direction of the board.**

(40) Experimental/Investigational/Unproven. A treatment, procedure, device, or drug that meets any of the criteria listed below is considered experimental/investigational/unproven and is not eligible for coverage under the plan. Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community. Experimental/investigational/unproven is defined as a treatment, procedure, device, or drug that the plan administrator determines, in the exercise of its discretion:
(A) Has not received the approval of the U.S. Food and Drug Administration for marketing the drug or device at the time it is furnished, if such approval is required by law;
(B) Is shown by reliable evidence to be the subject of ongoing Phase I clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or
(C) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficiency as compared with the standard means of treatment or diagnosis.

(41) First eligible. The first thirty-one (31)-day period after a member's employment date in which the member and his/her dependents may enroll in an MCHCP plan. As a member acquires new dependents, his/her first eligible period is the first thirty-one (31) days from the date the dependent meets the eligibility requirements for coverage under the plan.

(42) Formulary. A list of drugs covered by the pharmacy program claims administrator and as allowed by the plan administrator.

(43) Generic drug. A chemical equivalent of a brand-name drug with an expired patent. The color or shape may be different, but the active ingredients must be the same for both.

(44) Grievance. A written complaint submitted by or on behalf of a member regarding either:

(A) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or

(B) Claims payment, handling, or reimbursement for health care services.

(45) Group health plan. A plan maintained by an employer or an employee organization to provide medical care or other health services, directly or indirectly, to employees, former employees, and their families, including but not limited to Medicare and Medicaid plans.

(46) Handbook. The summary plan document prepared for members explaining the terms, conditions, and all material aspects of the plan and benefits offered under the plan, a copy of which is incorporated by reference into this rule. The full text of material incorporated by reference will be made available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, 2010 State Member Handbook (January 1, 2010). It does not include any later amendments or additions.

[(U) Health maintenance organization (HMO)—An organization that provides for a wide range of comprehensive health care services for a specified group at a fixed periodic prepayment;]

(47) Health savings account (HSA). A tax-advantaged savings account that may be used to pay current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA. HSA funds can be used to help pay the deductible, coinsurance, and any qualified medical expenses not covered by the health plan.

(48) High Deductible Health Plan (HDHP). A health plan with higher deductibles than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

*[(V)]***(49)** Home health agency*[—]***.** An agency certified by **Medicare and** the Missouri Department of Health and Senior Services, or any other state's licensing or certifying body, to provide health care services to persons in their homes*[;]***.**

*[(W)]***(50)** Hospice*[—A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill;]***. A public agency, private organization, or a subdivision of either that primarily engages in providing care to terminally ill individuals, meets the conditions of participation for hospices, holds a valid Medicare provider agreement, and is licensed pursuant to state law.**

(51) Hospice facility. A public or private organization, certified by Medicare and any other state's licensing or certifying body, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill. The facility must have an interdisciplinary medical team consisting of at least one (1) physician, one (1) registered nurse, one (1) social worker, one (1) volunteer, and a volunteer program. A hospice facility is not a facility, or part thereof, which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics, or a hotel or similar institution.

*[(X)]***(52)** Hospital.

*[1.]***(A)** An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic**,** and surgical facilities, all of which must be provided on its premises, under the supervision of a staff of one (1) or more physicians and with twenty-four (24)-hour-a-day nursing service by a registered nurse (RN) on duty or call.

*[2.]***(B)** An institution not meeting all the requirements of *[(1)(X)1. of this rule]* **(52)(A) above**, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

*[3.]***(C)** An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of Public Law 89-97).

*[4.]***(D)** A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.

*[5.]***(E)** A residential alcoholism, chemical dependency**,** or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction.

(F) In no event shall the term hospital include a skilled nursing facility or any institution**,** or part thereof**,** which is used primarily as a skilled nursing facility, nursing home, rest home**,** or facility for the aged*[;]***.**

(53) Hospital copayment. Set dollar amount a subscriber must pay for each hospital admission.

(54) Hospital room charges. The hospital's most common charge for semi-private accommodations, or the most common charge for a private room if that is the only type of room available or if a private room has been recommended by a physician and approved by the claims administrator or the plan administrator.

(55) Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered as any other illness.

(56) Incident. A definite and separate occurrence of a condition.

(57) Infertility. Any medical condition causing the inability or diminished ability to reproduce.

(58) Infertility services. Services including confinement, treatment, or other services related to the restoration of fertility or the promotion of conception.

(59) Injury. A condition that results independently of an illness and all other causes and is a result of an external force or accident.

(60) Inpatient. Confined to a registered bed. Patient in hospital, skilled nursing facility, hospice facility, or free-standing chemical dependency treatment center.

(61) Legend. Any drug that requires a prescription from either a physician or a practitioner, under either federal or applicable state law, in order to be dispensed.

(62) Life events. Events occurring in an individual's life to include: marriage, birth, adoption, or placement of children.

*[(Y)]***(63)** Lifetime*[—]***.** The period of time *[you or your]* **a member or the member's** eligible dependents participate in the plan*[;]***.**

(64) Lifetime maximum. The maximum amount payable by a medical plan during a covered member's life.

*[(Z)]***(65)** Medical benefits coverage*[—]***.** Services that are received from providers recognized by the plan and are covered benefits under the plan*[;]***.**

*[(AA)]***(66)** Medically necessary*[—Services and/or supplies usually rendered or prescribed for the specific illness or injury;]***. Treatments, procedures, services, or supplies that the plan administrator determines, in the exercise of its discretion:**

(A) Are expected to be of clear clinical benefit to the patient;

(B) Are appropriate for the care and treatment of the injury or illness in question; and

(C) Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service, or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a provider has prescribed, ordered, or recommended a treatment, procedure, service, or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service, or supply must not be specifically excluded from coverage under this plan.

(67) Member. Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

(68) Morbid obesity. Body Mass Index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled comorbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions approved by the plan administrator based on clinical review.

(69) Network provider. A physician, hospital, pharmacy, etc., that is contracted with the plan.

(70) Non-embedded deductible. The family deductible that must be met before claim payments begin, applicable when two (2) or more family members are covered in the HDHP.

(71) Non-formulary. A drug not contained on the pharmacy program's formulary list but may be covered under the terms and conditions of the plan.

(72) Non-network provider or non-participating provider. Any physician, hospital, pharmacy, etc., that does not have a contract with the plan.

*[(BB)]***(73)** Nurse*[—]***.** A registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule*[;]***.**

(74) Nursing home. An institution operated, pursuant to law, primarily for custodial care or for patients convalescing from illness or injury, under the supervision of a physician or registered nurse and having twenty-four (24)-hour nursing care. Also, an institution meeting the preceding criteria which is established for the treatment of sick and injured persons through spiritual means and is operated under the authority of organizations which are recognized under Medicare.

*[(CC)]***(75)** Open enrollment period*[—]***.** A period designated by the plan during which subscribers may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year*[;]***.**

*[(DD)]***(76)** Out-of-area*[—]***.** Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria*[;]***.**

*[(EE)]***(77)** Out-of-network*[—]***.** Providers that do not participate in the member's health **or pharmacy** plan*[;]***.**

(78) Out-of-pocket maximum. The maximum amount the member must pay before the plan begins paying one hundred percent (100%) of covered charges for the remainder of the calendar year.

(79) Outpatient. Treatment either outside a hospital setting or at a hospital when room and board charges are not incurred.

(80) Outpatient observation stay. Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Most observation services are less than twenty-four (24) hours. Members may receive observation services in the emergency room, an observation unit, the intensive care unit, or a regular floor.

(81) Palliative services. Care provided by a team approach that improves the quality of life for patients and their families facing problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

(82) Partial hospitalization. A distinct and organized intensive ambulatory treatment service, less than twenty-four (24)-hour daily care specifically designed for the diagnosis and active treatment of a mental/nervous disorder when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.

(A) Partial hospitalization programs must provide diagnostic services; services of social workers; psychiatric nurses and staff trained to work with psychiatric patients; individual, group, and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions for therapeutic purposes.

(B) The facility providing the partial hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a physician.

*[(FF)]***(83)** Participant*[—]***.** Any employee or dependent accepted for membership in the plan*[;]***.**

(84) Pharmacy benefit manager (PBM). Acts as a link between the parties involved in the delivery of prescription drugs to health plan members. The PBM designs, implements, and manages the overall drug benefit of the plan and processes claims payments.

*[(GG)]***(85)** Physically or mentally disabled*[—]***.** The inability of a person to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition*[;]***.**

*[(HH)]***(86)** Physician/Doctor*[—]***.** A licensed practitioner of the healing arts, acting within the scope of his/her practice as licensed under section 334.021, RSMo*[;]***.**

*[(II)]***(87)** Plan*[—]***.** The program of health care benefits established by the trustees of the Missouri Consolidated Health Care Plan as authorized by state law*[;]***.**

*[(JJ)]***(88)** Plan administrator*[—]***.** The trustees of the Missouri Consolidated Health Care Plan*[;]***. As such, the board is the sole**

fiduciary of the plan, has all discretionary authority to interpret its provisions and to control the operation and administration of the plan, and whose decisions are final and binding on all parties.

*[(KK)]***(89)** Plan document*[—]***.** The statement of the terms and conditions of the plan as *[adopted by the plan administrator in the "2005 Missouri Consolidated Health Care Plan Public Entity Employee Member Handbook" with respect to dental and vision coverage and incorporated by reference in this rule, as published in August 2004 by the Missouri Consolidated Health Care Plan, PO Box 104355, Jefferson City, MO 65110. This rule does not incorporate any subsequent amendments or additions. Note: The plan documents for medical plans are provided by the fully-insured contractors of such plans, and such plan documents may be obtained by contacting those contractors directly. The names, addresses, and phone numbers of the fully-insured contractors may be found in the "2005 Missouri Consolidated Health Care Plan Public Entity Employee Member Handbook";]* **promulgated by the plan administrator in this chapter.**

*[(LL)]***(90)** Plan year*[—]***.** Same as *[benefit]* **calendar** year*[;]***.**

[(MM) Point-of-service (POS)—A plan which provides a wide range of comprehensive health care services, like an HMO, if in-network providers are utilized, and like a PPO plan, if non-network providers are utilized;

(NN) Pre-admission testing—X-rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission;]

(91) Pre-admission testing. X-rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission.

(92) Pre-certification. Also known as pre-admission certification, pre-admission review, and pre-certification. The process of obtaining certification or authorization from the plan for routine hospital admissions and surgical or diagnostic procedures (inpatient or outpatient).

(93) Pre-existing condition. A condition for which a member has incurred medical expenses or received treatment prior to the effective date of coverage.

*[(OO)]***(94)** Preferred provider organization (PPO)*[—]***.** An arrangement with providers where discounted rates are given to members of the plan who, in turn, are offered a financial incentive to use these providers*[;]***.**

(95) Prevailing fee. The fee charged by the majority of dentists.

(96) Primary care physician (PCP). A physician (usually an internist, family/general practitioner, or pediatrician) who has contracted with and been approved by a medical plan.

(97) Prior authorization. A cost control procedure that requires the service or medication to be approved in advance by the doctor and/or the plan. Without prior authorization, the plan may not pay for the test, drug, or service. Also known as pre-authorization or pre-notification.

*[(PP)]***(98)** Prior plan*[—]***.** The terms and conditions of a plan in effect for the period preceding coverage in the *[MCHCP;]* **plan.**

(99) Private duty nursing. Private duty nursing services, nursing care on a full-time basis in the member's home, or home health aides.

(100) Proof of eligibility. Documentation required by the plan to determine a dependent's qualification for health insurance coverage.

(101) Proof of insurance. Evidence in written form from an insurance company that provides verification of coverage for a given period of time.

(102) Proof of prior coverage. If a member or his/her dependents enroll in an MCHCP plan due to loss of coverage, the member must provide proof of prior group coverage. This includes a letter from the previous insurance carrier or former employer which states all the following:

(A) Date coverage was or will be terminated;

(B) Reason for coverage termination; and

(C) List of dependents covered.

(103) Prostheses. An artificial extension that replaces a missing part of the body. Prostheses are typically used to replace parts lost by injury (traumatic) or missing from birth (congenital) or to supplement defective parts.

(104) Protected health information. Any information, whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse. This information also relates to the past, present, or future physical or mental health or condition of the individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to the individual.

*[(QQ)]***(105)** Provider*[—]***.** Hospitals, physicians, chiropractors, medical agencies, or other specialists who provide medical care within the scope of his/her practice and are recognized under the provisions *[and administrative guidelines]* of the plan. Provider also includes a qualified practitioner of an organization which is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized*[;]***.**

(106) Provider directory. A listing of network providers within a health plan.

(107) Prudent layperson. An individual possessing an average knowledge of health and medicine.

*[(RR)]***(108)** Public entity*[—]***.** A state-sponsored institution of higher learning, political subdivision**,** or governmental entity or instrumentality that has elected to join the plan and has been accepted by the board*[;]***.**

(109) Qualified Medical Child Support Order (QMCSO). A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or an enrollee if the plan normally provides coverage for dependent children.

(110) Reconstructive surgery. A procedure performed to restore the anatomy and/or functions of the body that are lost or impaired due to an injury or illness.

(111) Refractions. A record of the patient's preference for the focusing of the eyes that can then be used to purchase eyeglasses.

It is the portion of the eye exam that determines what prescription lens provides the patient with the best possible vision.

(112) Rehabilitation facility. A legally operating institution, or distinct part of an institution, that has a transfer agreement with one (1) or more hospitals and is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute hospital, and rehabilitative inpatient care, and is duly licensed by the appropriate government agency to provide such services.

(A) It does not include institutions that provide only minimal care, custodial care, ambulatory or part-time care services, or an institution that primarily provides treatment of mental/nervous disorders, substance abuse, or tuberculosis, except if such facility is licensed, certified, or approved as a rehabilitation facility for the treatment of mental/nervous conditions or substance abuse in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) or the Commission for the Accreditation of Rehabilitation Facilities.

(113) Retiree. A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-3.020(6)(B) and is currently receiving a monthly retirement benefit from one (1) of the retirement systems listed in such rule.

[(SS) Review agency—A company responsible for administration of clinical management programs;]

*[(TT)]***(114)** Second opinion program*[—]***.** A consultation and/or exam with a physician qualified to perform the procedure who is not affiliated with the attending physician/surgeon, for the purpose of evaluating the medical necessity and advisability of undergoing a surgical procedure or receiving a service*[;]***.**

(115) Skilled nursing care. Care which must be performed by, or under the supervision of, licensed personnel and meets criteria as established by the claims administrator.

*[(UU)]***(116)** Skilled nursing facility (SNF)*[—]***.** An institution which meets fully each of the following requirements:

*[1.]***(A)** It is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, the following services for persons convalescing from sickness or injury: room, board**,** and twenty-four (24)-hour-a-day nursing service by one (1) or more professional nurses and nursing personnel as are needed to provide adequate medical care;

*[2.]***(B)** It provides the services under the supervision of a proprietor or employee who is a physician or registered nurse; and it maintains adequate medical records and has available the services of a physician under an established agreement, if not supervised by a physician or registered nurse; and

*[3.]***(C)** A skilled nursing facility shall be deemed to include institutions meeting the criteria in *[subsection (1)(UU) of]* this rule which are established for the treatment of sick and injured persons through spiritual means and are operated under the authority of organizations which are recognized under Medicare (Title I of Public Law 89-97)*[;]***.**

(117) Sound natural teeth. Teeth and/or tissue that is viable, functional, and free of disease. A sound natural tooth has no decay, fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.

(118) Specialty care physician/specialist. A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

(119) Specialty medications. High cost drugs that are primarily self-injectible but sometimes oral medications.

*[(VV)]***(120)** State*[—]***.** Missouri*[;]***.**

(121) Step therapy. Designed to encourage use of therapeutically-equivalent, lower-cost alternatives before stepping up to more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

(122) Subrogation. The substitution of one (1) "party" for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan to stand in the place of the participant and recover the money directly from the other insurer.

*[(WW)]***(123)** Subscriber*[—]***.** The employee or member who elects coverage under the plan*[;]***.**

(124) Subscriber only participation. Participation of a subscriber without participation of the subscriber's dependents, whether or not the subscriber has dependents.

(125) Surgery. Any operative or invasive diagnostic procedure performed in the treatment of an injury or illness by an instrument or cutting procedure through any natural body opening or incision.

(126) Surgery center (ambulatory). A hospital based, sponsored, or independently-owned facility that performs surgery.

*[(XX)]***(127)** Survivor*[—]***.** A member who meets the requirements of **subsection** 22 CSR 10-3.020(6)(A)*[;]***.**

*[(YY)]***(128)** Unemancipated child(ren). A natural child(ren), a legally adopted child(ren) or a child(ren) placed for adoption, and a dependent disabled child(ren) over twenty-five (25) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:

*[1.]***(A)** Stepchild(ren);

*[2.]***(B)** Foster child(ren) for whom the employee is responsible for health care;

*[3.]***(C)** Grandchild(ren) for whom the employee has legal custody and is responsible for providing health care; **and**

*[4.]***(D)** Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator.

(E) Except for a disabled child(ren) as described in *[sub]*section *[(1)(GG)]***(85)** of this rule, an unemancipated child(ren) is eligible from birth to the end of the month in which s/he is emancipated, as defined here, or attains age twenty-five (25) (see **paragraph** 22 CSR 10-3.020(4)(D)2. for continuing coverage on a handicapped child(ren) beyond age twenty-five (25)); and

*[5.]***(F)** Stepchild(ren) who are not domiciled with the employee, provided the natural parent who is legally responsible for providing coverage is also covered as a dependent under the plan*[;]***.**

(129) Urgent care. Medically necessary services in order to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate

for injuries too severe to be seen in a primary care physician office but not severe enough to require treatment in a hospital emergency department.

(130) Urgent care centers. Medical facilities that provide extended or twenty-four (24)-hour service to treat minor conditions at a lower cost than emergency room treatment.

*[(ZZ)]***(131)** Usual, *[c]***C**ustomary, and *[r]***R**easonable *[c]***C**harge*[—]***.**

*[1.]***(A)** Usual—The fee a physician most frequently charges the majority of his/her patients for the same or similar services*[;]***.**

*[2.]***(B)** Customary—The range of fees charged in a geographic area by physicians of comparable skills and qualifications for the same performance of similar service*[;]***.**

*[3.]***(C)** Reasonable—The flexibility to take into account any unusual clinical circumstances involved in performing a particular service*[; and]***.**

*[4.]***(D)** A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the doctors for ninety percent (90%) of the procedures reported*[; and]***.**

(132) Utilization review. Evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities on a prospective, concurrent, or retrospective basis.

*[(AAA)]***(133)** Vested subscriber*[—]***.** A member who meets the requirements of **subsection** 22 CSR 10-3.020(6)(B).

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Emergency amendment filed Dec. 20, 2007, effective Jan. 1, 2008, expired June 28, 2008. Amended: Filed Dec. 20, 2007, effective June 30, 2008. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed amendment covering this same material is published in this issue of the ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.020 Subscriber Agreement and General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (1), (3), (4), and (6)–(9).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the subscriber agreement and general membership provisions of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be effective immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) The participant's initial application, any subsequently accepted modifications to such application, **the handbook,** and the plan document as adopted by the board along with duly executed amendments shall comprise the subscriber agreement between the participant and the Missouri Consolidated Health Care Plan (MCHCP). Any *[associated administrative guidelines]* **other written materials** interpret**ing** the subscriber agreement for the benefit of members and administrators *[but]* are not part of the subscriber agreement.

(A) By applying for coverage under the MCHCP**,** a participant agrees that—

1. The employer may deduct the cost of the premium for the employee's plan from the employee's paychecks; and

2. Individual and family deductibles, if appropriate, will be applied. Deductibles previously paid to meet the requirements of the prior plan may be credited for those joining one **(1)** of the preferred provider organization (PPO) options. Appropriate proof of said deductibles will be required.

(3) The effective date of participation shall be determined, subject to the effective date provision in subsection (3)(C), as follows:

(A) Employee Participation.

1. If application by an employee is made on or before the date of eligibility, participation shall become effective on such date of eligibility;

2. If application by an employee is made within thirty-one (31) days after the date of eligibility, participation may become effective on the date of eligibility or the first day of the calendar month coinciding with or following the date *[of]* **the** application **is received**, except that participation shall be retroactive to the beginning of the month for employees rehired during the month following the month participation would have terminated; and

3. Not limiting or excluding any of the other provisions, if application is not made within thirty-one (31) days of the employee's date of eligibility, they may apply for coverage only if *[a life event occurs. Life events include: marriage, birth, adoption, death, divorce, legal separation, job loss or failure to elect continuation of coverage. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify the plan administrator of the life event;]* **one (1) of the following occurs:**

A. Occurrence of a life event which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify the plan administrator of the life event;

B. Loss of a spouse's employer-sponsored group coverage when the employee originally waived coverage through the plan. Application must be made within sixty (60) days of the time—

(I) The employee no longer qualifies for coverage under spouse's plan;

(II) The spouse's employment terminates or he/she is no longer eligible for coverage under employer's plan;

(III) The spouse's employer-sponsored medical, dental, and/or vision plan terminates;

(IV) All employer contributions toward the spouse's plan cease; or

(V) The employee's Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends; or

C. Loss of eligibility for Medicaid, in which case application for coverage through the plan must be made within sixty (60) days of the loss;

(B) Dependent Coverage. Dependent participation cannot precede the subscriber's participation **except when coverage is added as a life event with birth of a child or adoption of a child at birth. The effective date for a child is the date of birth. The subscriber and/or dependent's effective date is the first day of the calendar month coinciding with or following the date of the application**. Application for participants must be made in accordance with the following provisions*[.]***:**

1. For family coverage, once a subscriber is participating with respect to dependents, newly acquired dependents are automatically covered on their effective dates as long as the plan administrator is notified within thirty-one (31) days of the person becoming a dependent. First eligible dependents must be added within thirty-one (31) days of such qualifying event. The employee is required to notify the plan administrator on the appropriate form of the dependent's name, date of birth, eligibility date**,** and Social Security number, if available. Claims will not be processed until the required information is provided*[.]***;**

*[1.]***2.** If an employee makes concurrent application for dependent participation on or before the date of eligibility or within thirty-one (31) days thereafter, participation for dependent will become effective on the date the employee's participation becomes effective;

*[2.]***3.**When an employee participating in the plan first becomes eligible with respect to a dependent child(ren), coverage may become effective on the eligibility date or the first day of the month coinciding with or following the date of eligibility if application is made within thirty-one (31) days of the date of eligibility and provided any required contribution for the period is made; **and**

[3. Unless required under federal guidelines—

A. An emancipated dependent who regains his/her dependent status is immediately eligible for coverage if an application is submitted within thirty-one (31) days of regaining dependent status; and

B. An eligible dependent that is covered under a spouse's health plan who loses eligibility under the criteria stipulated for dependent status under the spouse's health plan is not eligible for coverage until the next open enrollment period. (Note: Subparagraphs (3)(B)3.A. and B. do not include dependents of retirees or long-term disability members covered under the plan); and]

4. Survivors, retirees, vested subscribers**,** and long-term disability subscribers may only add dependents to their coverage when the dependent is first eligible for coverage*[;]***, except when a dependent's employer-sponsored coverage ends due to one (1) of the following:**

A. Termination of employment;

B. Retirement; and

C. Termination of group coverage by the employer.

Coverage must have been in place for twelve (12) months immediately prior to the loss, and coverage must be requested within sixty (60) days from the termination date of the previous coverage;

(C) Effective Date *[Proviso]* **Provision**.

1. In any instance when the employee is not actively working full-time on the date participation would otherwise have become effective, participation shall not become effective until the date the employee returns to full-time active work. However, this provision shall not apply for public entities (or any individual who is a member of that public entity) when the MCHCP is replacing coverage for that public entity;

[(D) Application for dependent coverage may be made at other times of the year when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's: 1) employment is terminated or is no longer eligible for coverage under his/her employer's plan, or 2) employer-sponsored medical plan is terminated. With respect to dependent child(ren) coverage, application may also be made at other times of the year when the member receives a court order stating s/he is responsible for providing medical coverage for the dependent child(ren) or when the dependent loses Medicaid coverage. Dependents added under any of these exceptions must supply verification from the previous insurance carrier or the member's employer that they have lost coverage and the effective date of termination. Coverage must also be requested within sixty (60) days from the termination date of the previous coverage. Application must be made within sixty (60) days of the court order. (Note: This section does not include dependents of retirees, survivors, vested subscribers, or long-term disability subscribers covered under the plan); and

(E) When an employee experiences applicable life events, eligibility will be administered according to Health Insurance Portability and Accountability Act (HIPAA) guidelines.]

(D) Application for dependent coverage may be made within sixty (60) days when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's:

1. Employer-sponsored medical plan terminates or coverage by the employer is no longer offered;

2. The employer contributions toward the premiums cease; or

3. A dependent no longer qualifies due to age;

(E) Application may be made for dependent coverage within sixty (60) days of the event—

1. A Qualified Medical Child Support Order is received;

2. A dependent no longer qualifies for Medicaid; or

(F) Application may be made for dependent coverage within thirty-one (31) days of an emancipated dependent regaining dependent status.

(4) Termination of participation shall occur on the last day of the calendar month coinciding with or following the happening of any of the following events, whichever shall occur first:

(D) Termination of Eligibility for Participation.

1. With respect to employees, termination of participation shall occur upon termination of employment in a position covered by the MCHCP, except as specified in sections (5) and (6).

2. With respect to dependents, termination of participation shall occur upon ceasing to be a dependent as defined in this rule with the following exception: unemancipated mentally *[retarded]* and/or physically handicapped children will continue to be eligible beyond age twenty-five (25) during the continuance of a permanent disability provided documentation satisfactory to the plan administrator is furnished by a physician prior to the dependent's twenty-fifth birthday, and as requested at the discretion of the plan administrator.

3. Termination of employee's participation shall terminate the participation of dependents, except as specified in section (6).

(6) Continuation of Coverage.

(A) Dependents. Termination of an active employee's participation by reason of death shall not terminate participation with respect to the surviving spouse and/or dependent children if *[—]*

*[1. T]***t**he active employee was vested and eligible for a future retirement benefit*[; or]* **and**

[2. Your] eligible dependents meet one (1) of the following conditions:

*[A.]***1.** They have had coverage through MCHCP since the effective date of the last open enrollment period;

*[B.]***2.** They have had other health insurance for the six (6) months immediately prior to *[your]* **the employee's** death—proof of insurance is required; or

*[C.]***3.** They have had coverage through MCHCP since they were first eligible.

(B) Employee Eligible for Retirement Benefits. Any employee who, at the time of termination of employment, met the following—

1. Eligibility Criteria:

A. Coverage through MCHCP since the effective date of the last open enrollment period;

B. Other health insurance for the six (6) months immediately prior to the termination of state employment—proof of insurance is required; or

C. Coverage since first eligible;

2. Immediately eligible to receive a monthly retirement benefit from the retirement system of the participating public entity may elect to continue to participate in the plan by paying the cost of plan benefits as determined by the plan administrator. An employee must apply for continued coverage within thirty-one (31) days of the first day of the month following the date of retirement. An employee, continuing coverage under this provision, may also continue coverage for eligible dependents.

A. If a member participates in the MCHCP as a vested member, his/her dependents may also participate if they meet one (1) of the following criteria:

(I) They have had coverage through MCHCP since the effective date of the last open enrollment period;

(II) They have had other health insurance for the six (6) months immediately prior to state employment termination—proof of insurance is required; or

(III) They have had coverage since they were first eligible;

3. In the case of the death of a retiree who was maintaining dependent coverage under this provision, the dependent of the deceased retiree may continue his/her participation under the plan. However, retirees, survivors, vested subscribers**,** and long-term disability subscribers and their dependents are not later eligible if they discontinue their coverage at some future time, except as noted in *[(7)(B)4.]* **paragraph (6)(B)4.**; and

4. A vested or retired member may elect to suspend their coverage upon entry into the armed forces of any country by submitting a copy of their activation papers within thirty-one (31) days of their activation date. Coverage will be suspended the first of the month following the month of activation. Coverage may be reinstated at the same level upon discharge by submitting a copy of their separation papers and a completed enrollment form within thirty-one (31) days of their separation date. Coverage will be reinstated as of the first of the month following the month of separation.

(D) Leave of Absence. An employee on approved leave of absence may elect to retain eligibility to participate in the plan by paying the required contributions. The employing department must officially notify the plan administrator of the leave of absence and any extension of the leave of absence by submitting the required form. Any employee on an approved leave of absence who was a member of the Missouri Consolidated Health Care Plan when the approved leave began, but who subsequently terminated participation in the Missouri Consolidated Health Care Plan while on leave, may recommence his/her coverage in the plan at the same level (employee only*[,]* or employee and dependents) upon returning to employment directly from the leave*[, but they will be subject to preexisting limitations, when applicable. Preexisting limitations under this provision will not apply to health maintenance organization (HMO) or point-of-service (POS) members]*. However, eligibility is terminated for those members receiving a military leave of absence, as specified in subsection *[(5)(C)]***(4)(C)**. Coverage may be reinstated upon return from military leave *[without proof of insurability or preexisting conditions]*. However, the former member must complete an enrollment form. Coverage under this provision is effective on the first of the month coinciding with or following the employee's return to work. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date and timely requests reinstatement of coverage.

(F) Workers' Compensation. Any person who is receiving, or is entitled to receive, Workers' Compensation benefits as a result of an injury or accident sustained in employment and who was a member of the plan at the time of becoming disabled may continue his/her coverage in the plan at the same level of participation *[(employee only or employee and dependents)]* **(subscriber only or subscriber and dependents)** by paying the required contributions, if the disability occurred in the employment through which the employee qualifies for membership in the plan. Any person receiving, or entitled to receive, Workers' Compensation benefits who was a member of the plan at the time of becoming disabled as a result of an injury or accident sustained in employment through which the person qualified for membership in the plan, but who subsequently terminated participation in the plan, may recommence his/her coverage in the plan at the same level *[(employee only, or employee and dependents)]* **(subscriber only or subscriber and dependents)** upon returning to employment*[, without proving insurability]*.

(G) Reinstatement After Dismissal. If an employee is approved to return to work after being terminated as a result of legal or administrative action available as a recourse through his/her employer, s/he will be allowed to reinstate his/her medical benefit retroactively to the date of dismissal. If the employee is reinstated with back pay, s/he will be responsible for paying any contribution normally made for either his/her coverage or his/her covered dependents. *[No preexisting condition limitation will apply.]* If the employee is reinstated without back pay, s/he will be considered to have been on a leave of absence. Consequently, the employee will be responsible for making any required contribution toward the cost of his/her medical benefits. If the employee does not purchase coverage for the period between termination and reinstatement, s/he may regain the same level of coverage s/he had prior to termination. *[If the employee participates in a PPO plan, the preexisting condition limitation will apply if coverage lapsed more than sixty-three (63) days. This does not apply if the employee participates in an HMO or POS.]*

(7) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) In accordance with the COBRA, eligible employees and their dependents may continue their medical coverage after the employee's termination date.

1. Employees terminating for reasons other than gross misconduct **or receiving a reduction in the number of hours of employment** may continue coverage for themselves and their covered dependents for eighteen (18) months at their own expense.

2. A surviving spouse and dependents, not normally eligible for continued coverage, may elect coverage for up to thirty-six (36) months at their own expense.

3. A divorced spouse may continue coverage at his/her own expense for up to thirty-six (36) months if the plan administrator is notified within sixty (60) days from the date coverage would terminate.

4. Dependent spouse and/or child(ren) may continue coverage up to thirty-six (36) months if the covered employee retires and the dependent spouse/child(ren) has not been covered by the plan for two (2) years.

5. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense if the plan administrator is notified within sixty (60) days of the loss of the dependent's eligibility.

6. Employees who are disabled at termination or become disabled during the first sixty (60) days of coverage may continue coverage for up to twenty-nine (29) months.

7. Premiums for continued coverage will be one hundred two percent (102%) of the health plan rate, one hundred fifty percent

(150%) if disabled. Once coverage is terminated under the COBRA provision**,** it cannot be reinstated.

8. All operations under the COBRA provision will be applied in accordance with federal regulations.

(8) Missouri State Law COBRA Wrap-Around Provisions—Missouri law provides that if *[you lose your]* **a member loses** group health insurance coverage because of a divorce, legal separation**,** or the death of *[your]* **a** spouse**,** *[you]* **the member** may continue coverage until age sixty-five (65) if: a) *[You]* **The member** continue**s** and maintain**s** coverage under the thirty-six (36)-month provision of COBRA; and b) *[You are]* **The member is** at least fifty-five (55) years old when *[your]* COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions and will have to pay all of the application premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium. The above Cancellation of Continuation Coverage also applies to COBRA wrap-around continuation.

[(9) Medicare—Participants eligible for Medicare who are not eligible for this plan as their primary plan, shall be eligible for benefits no less than those benefits for participants not eligible for Medicare. For such participants who elect to continue their coverage, benefits of this plan shall be coordinated with Medicare benefits on the then standard coordination of benefits basis to provide up to one hundred percent (100%) reimbursement for covered charges.

(A) If a participant eligible for Medicare who is not eligible for this plan as the primary plan is not covered by Medicare, an estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim submitted basis so that if, for a given claim, Medicare reimbursement was for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims; and]

*[(B)]***(9)** If any retired participants or long-term disability recipients, their eligible dependents**,** or surviving dependents eligible for coverage elect not to be continuously covered from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Emergency amendment filed Dec. 20, 2007, effective Jan. 1, 2008, expired June 28, 2008. Amended: Filed Dec. 20, 2007, effective June 30, 2008. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed amendment covering this same material is published in this issue of the ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.030 Public Entity Membership Agreement and Participation Period. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the Public Entity Membership Agreement and Participation Period of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be effective immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) The application packet, participation agreement, and confirmation notice shall comprise the membership agreement between a public entity and the Missouri Consolidated Health Care Plan (MCHCP).

(A) By applying for coverage under the MCHCP**,** a public entity agrees that—

1. The MCHCP will be the only health care offering made to its eligible members;

[2. If the public entity participated in the MCHCP during calendar year 2004 and continues to participate each year subsequent to calendar year 2004, that public entity shall only be required to contribute twenty-five dollars ($25) per month towards the employee only premium for each active employee's premium for the plan(s) offered through MCHCP during calendar years 2005 and 2006;]

*[3.]***2.** *[If the public entity did not participate in the MCHCP during calendar year 2004, that]* **The** public entity shall contribute at least fifty percent (50%) of the lowest cost employee only premium per month toward each active employee's premium for the plan(s) offered through MCHCP;

[4. Beginning January 1, 2007, all public entities shall contribute at least fifty percent (50%) of the lowest cost employee only premium per month toward each active employee's premium for the plan(s) offered through MCHCP;]

*[5.]***3.** For public entities with less than twenty-five (25) employees, the public entity shall only offer one (1) plan choice to its employees. For public entities with twenty-five (25) or more employees, the public entity may offer *[more than one (1)]* **two (2)** plans *[choice]* provided by MCHCP*[.]***;**

*[6.]***4.** For public entities with more than a total of three (3) employees, at least seventy-five percent (75%) of all eligible employees must join the MCHCP*[. For public entities with three (3) or fewer employees, a minimum of one (1) employee must join the MCHCP. For public entities with three (3) or fewer employees who fail to have one (1) employee participating in the MCHCP, MCHCP will allow the public entity up to the remainder of the period remaining in the latest participation agreement in which to attempt to meet the participation requirements before terminating for failure to meet the participation requirements]*;

*[7.]***5.** Individual and family deductibles, if applicable, will be applied. Deductibles previously paid to meet the requirements of the terminating plan may be credited for those joining *[one of the PPO options]* **MCHCP**. Appropriate proof of said deductibles will be required;

*[8.]***6.** An eligible employee is one that is not covered by another group sponsored plan;

*[9.]***7.** Any individual eligible as an employee may be covered as either an employee or dependent, but not both. Employees enrolled as dependents will not be considered as eligible employees in consideration of section (6); and

*[10.]***8.** A public entity may apply a probationary period, not to exceed applicable federal guidelines, before benefits become effective.

(B) *[Effective January 1, 2001, i]***I**n order to provide retiree coverage, any participating member agency joining MCHCP must have one **(1)** of the criteria listed below. If neither of these scenarios is applicable and no retirement plan exists, no "retirees" would exist, so there would be no retiree eligibility.

1. An established retirement plan with contributions shared by both the employee and the employer (or made by the employer only) with an established minimum vesting period. The employer must offer coverage to retirees who have met this minimum vesting period requirement.

2. An employer-sponsored (but no contribution made by employer) retirement plan in which the employee is currently participating or from which the employee is eligible to receive a benefit. In this case, in order to be considered an eligible retiree, the prospective member must have met a vesting criterion equal to Missouri State Employees' Retirement System (MOSERS). If this criterion was not met, the employer may not offer coverage to that person as a retiree.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.045 Plan Utilization Review Policy

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program consists of four (4) parts, as described in the following:

(A) Precertification—The medical necessity of a non-emergency hospital admission, specified procedures as documented in the claims administrator's guidelines, and/or skilled nursing services provided on an inpatient basis must be prior authorized by the appropriate claims administrator. For emergency hospital admissions, the claims administrator must be notified within forty-eight (48) hours of the admission. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(B) Concurrent Review—The claims administrator will continue to monitor the medical necessity of the admission and approve the continued stay in the hospital. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(C) Large Case Management—Members who require long-term acute care may be offered the option of receiving the care, if appropriate, in a more cost-effective setting such as a skilled nursing facility or their own home. In some cases**,** this may require coverage for benefits that normally are not covered under the plan. These benefits may be provided through the approval of the claims administrator;

(D) Hospital Bill Audits—Certain hospital bills will be subject to review to verify that the services billed were actually provided and/or the associated billed amounts are accurate and appropriate; and

(E) Penalties—Members not complying with subsections (1)(A) and (B) of this rule may be subject to a financial penalty in connection with their covered benefits.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.050 Copay Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Copay Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also

help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Non-network deductible amount—per individual for the Copay Plan each calendar year, six hundred dollars ($600); family limit each calendar year, one thousand two hundred dollars ($1,200).

(2) Coinsurance—non-network coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once out-of-pocket maximum is reached.

(A) Coinsurance is seventy percent (70%) after deductible is met when utilizing non-network providers.

(B) The deductible is waived and claims are paid at eighty percent (80%) for the following services: home health care, infusion, durable medical equipment (DME), and audiologists.

(C) Claims may also be paid at eighty percent (80%) if the subscriber requires covered services that are not available through a network provider within fifty (50) miles of his/her home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(D) Non-network claims—are paid at seventy percent (70%) until two thousand four hundred dollars ($2,400) has been met for an individual, four thousand eight hundred dollars ($4,800) has been met for a family, of covered charges in the calendar year which are subject to coinsurance. Claims are paid at one hundred percent (100%) of any excess covered charges in the calendar year.

(3) Copayments—set charges for the following types of claims so long as network providers are utilized.

(A) Office visit—primary care: twenty-five dollars ($25); specialist: thirty-five dollars ($35).

(B) Laboratory and X-ray services—no copayment; covered at one hundred percent (100%).

(C) Inpatient hospitalizations—three hundred dollars ($300) per admission; one thousand two hundred dollars ($1,200) annual maximum inpatient copayment.

(D) Maternity—primary care: twenty-five dollars ($25) for initial visit; specialist: thirty-five dollars ($35).

(E) Preventive care—no copayment; covered at one hundred percent (100%).

(F) Outpatient surgery—one hundred dollars ($100).

(G) Emergency room—one hundred dollars ($100) network and non-network.

(H) Urgent care—thirty-five dollars ($35) network and non-network.

(4) Out-of-pocket non-network maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Non-network out-of-pocket maximum for individual—two thousand four hundred dollars ($2,400); and

(B) Non-network out-of-pocket maximum for family—four thousand eight hundred dollars ($4,800).

(C) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(5) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.051 PPO 300 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 300 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Deductible amount—Network: per individual each calendar year, three hundred dollars ($300); family limit each calendar year, six hundred dollars ($600). Non-network: per individual each calendar year, six hundred dollars ($600); family limit each calendar year, one thousand two hundred dollars ($1,200).

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of

the calendar year once out-of-pocket maximum is reached.

(A) Network claims—are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims may also be paid at ninety percent (90%) if the subscriber requires covered services that are not available through a network provider within fifty (50) miles of his/her home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network out-of-pocket maximum for individual—one thousand two hundred dollars ($1,200).

(B) Network out-of-pocket maximum for family—two thousand four hundred dollars ($2,400).

(C) Non-network out-of-pocket maximum for individual—two thousand four hundred dollars ($2,400).

(D) Non-network out-of-pocket maximum for family—four thousand eight hundred dollars ($4,800).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(4) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.052 PPO 500 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 500 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Deductible amount—Network: per individual each calendar year, five hundred dollars ($500); family limit each calendar year, one thousand five hundred dollars ($1,500). Non-network: per individual each calendar year, one thousand dollars ($1,000); family limit each calendar year, three thousand dollars ($3,000).

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once out-of-pocket maximum is reached.

(A) Network claims—are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims may also be paid at ninety percent (90%) if required covered services are not available through a network provider within fifty (50) miles of the member's home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(3) Copayments—set charges for the following types of claims so long as network providers are utilized.

(A) Office visit—Network: primary care—twenty dollars ($20), specialist—thirty dollars ($30); Non-network: seventy percent (70%) coinsurance after deductible.

(B) Maternity—Network: primary care—twenty dollars ($20) for initial visit, specialist—thirty dollars ($30) for initial visit; Non-network: seventy percent (70%) coinsurance after deductible.

(C) Preventive care—Network: no copayment, covered at one hundred percent (100%); Non-network: seventy percent (70%) coinsurance after deductible.

(D) Emergency room—Network: one hundred dollar ($100) copayment (waived if admitted as inpatient); Non-network: one hundred dollar ($100) copayment (waived if admitted as inpatient).

(E) Urgent care—Network: fifty dollar ($50) copayment; Non-network: fifty dollar ($50) copayment.

(4) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network out-of-pocket maximum for individual—two thousand five hundred dollars ($2,500).

(B) Network out-of-pocket maximum for family—seven thousand five hundred dollars ($7,500).

(C) Non-network out-of-pocket maximum for individual—seven thousand dollars ($7,000).

(D) Non-network out-of-pocket maximum for family—twenty-one thousand dollars ($21,000).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance

with prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(5) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 1000 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Deductible amount—Network: per individual each calendar year, one thousand dollars ($1,000); family limit each calendar year, three thousand dollars ($3,000). Non-network: per individual each calendar year, two thousand dollars ($2,000); family limit each calendar year, six thousand dollars ($6,000).

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once out-of-pocket maximum is reached.

(A) Network claims—are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims may also be paid at ninety percent (90%) if required covered services are not available through a network provider within fifty (50) miles of the member's home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(3) Copayments—set charges for the following types of claims so long as network providers are utilized.

(A) Office visit—Network: primary care—twenty dollars ($20), specialist—thirty dollars ($30); Non-network: seventy percent (70%) coinsurance after deductible.

(B) Maternity—Network: primary care—twenty dollars ($20) for initial visit, specialist—thirty dollars ($30) for initial visit; Non-network: seventy percent (70%) coinsurance after deductible.

(C) Preventive care—Network: no copayment, covered at one hundred percent (100%); Non-network: seventy percent (70%) coinsurance after deductible.

(D) Emergency room—Network: one hundred dollar ($100) copayment (waived if admitted as inpatient); Non-network: one hundred dollar ($100) copayment (waived if admitted as inpatient).

(E) Urgent care—Network: fifty dollar ($50) copayment; Non-network: fifty dollar ($50) copayment.

(4) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network out-of-pocket maximum for individual—four thousand five hundred dollars ($4,500).

(B) Network out-of-pocket maximum for family—thirteen thousand five hundred dollars ($13,500).

(C) Non-network out-of-pocket maximum for individual—ten thousand dollars ($10,000).

(D) Non-network out-of-pocket maximum for family—thirty thousand dollars ($30,000).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(5) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 2000 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees, and

their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Deductible amount—Network: per individual each calendar year, two thousand dollars ($2,000); family limit each calendar year, six thousand dollars ($6,000). Non-network: per individual each calendar year, four thousand dollars ($4,000); family limit each calendar year, twelve thousand dollars ($12,000).

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once out-of-pocket maximum is reached.

(A) Network claims—are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims may also be paid at eighty percent (80%) if required covered services are not available through a network provider within fifty (50) miles of the member's home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(3) Copayments—set charges for the following types of claims so long as network providers are utilized.

(A) Office visit—Network: primary care—twenty-five dollars ($25), specialist—thirty-five dollars ($35); Non-network: sixty percent (60%) coinsurance after deductible.

(B) Maternity—Network: primary care—twenty-five dollars ($25) for initial visit, specialist—thirty-five dollars ($35) for initial visit; Non-network: sixty percent (60%) coinsurance after deductible.

(C) Preventive care—Network: no copayment, covered at one hundred percent (100%); Non-network: sixty percent (60%) coinsurance after deductible.

(D) Emergency room—Network: one hundred dollar ($100) copayment (waived if admitted as inpatient); Non-network: one hundred dollar ($100) copayment (waived if admitted as inpatient).

(E) Urgent care—Network: fifty dollar ($50) copayment; Non-network: fifty dollar ($50) copayment.

(4) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network out-of-pocket maximum for individual—six thousand dollars ($6,000).

(B) Network out-of-pocket maximum for family—eighteen thousand dollars ($18,000).

(C) Non-network out-of-pocket maximum for individual—twelve thousand dollars ($12,000).

(D) Non-network out-of-pocket maximum for family—thirty-six thousand dollars ($36,000).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(5) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.055 High Deductible Health Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the High Deductible Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Deductible amount—Network: per individual each calendar year, one thousand two hundred dollars ($1,200); family limit each calendar year, two thousand four hundred dollars ($2,400). Non-network: per individual each calendar year, two thousand four hundred dollars

($2,400); family limit each calendar year, four thousand eight hundred dollars ($4,800).

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once out-of-pocket maximum is reached.

(A) Network claims—are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims may also be paid at eighty percent (80%) if required covered services are not available through network provider within fifty (50) miles of the member's home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network out-of-pocket maximum for individual—two thousand four hundred dollars ($2,400).

(B) Network out-of-pocket maximum for family—four thousand eight hundred dollars ($4,800).

(C) Non-network out-of-pocket maximum for individual—four thousand eight hundred dollars ($4,800).

(D) Non-network out-of-pocket maximum for family—nine thousand six hundred dollars ($9,600).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(4) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

(5) Pharmacy benefits are subject to the applicable medical plan deductible and coinsurance.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.060 PPO 300 Plan, PPO 500 Plan, PPO 1000 Plan, PPO 2000 Plan, HDHP, and Copay Plan Limitations

PURPOSE: This rule establishes the limitations and exclusions of the Missouri Consolidated Health Care Plan PPO 300 Plan, PPO 500 Plan, PPO 1000 Plan, PPO 2000 Plan, HDHP, and/or Copay Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges or within any of the sections of this rule.

(2) If applicable, all hospitalizations, outpatient treatment for chemical dependency, or mental and nervous disorder that do not receive prior authorization as described in 22 CSR 10-3.045, reimbursement will be reduced by ten percent (10%) of reasonable and customary charges.

(3) Abortion—other than situations where the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.

(4) Allergy services—no coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

(5) Alternative therapies—including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, biofeedback, and other forms of alternative therapy with the exception of aquatic therapy performed by a physical therapist.

(6) Autopsy.

(7) Blood storage, including whole blood, blood plasma, and blood products.

(8) Breast augmentation mammoplasty—not covered unless associated with breast surgery following a medically necessary mastectomy incurred secondary to active disease.

(9) Care received without charge.

(10) Comfort and convenience items.

(11) Cosmetic, plastic, reconstructive, or restorative surgery—unless medically necessary to repair a functional disorder caused by disease, injury, or congenital defect or abnormality (for a participant under the age of nineteen (19)) or to restore symmetry following a mastectomy.

(12) Custodial or domiciliary care—includes services and supplies that assist members in the activities of daily living like walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets and supervision of medication that is usually self-administered.

(13) Dental—treatment must be initiated within sixty (60) days of accident. Limited to treatment of accidental injury to sound natural teeth. Oral surgery is covered only when medically necessary as a direct result from injury, tumors, or cysts. Dental care, including oral surgery, as a result of poor dental hygiene is not covered. Extractions of bony or partial bony impactions are excluded.

(14) Durable medical equipment and disposable supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings, and support hose. Over-the-counter medications and supplies. Prescription compression stockings are limited to two (2) pairs of four (4) individual stockings per plan year.

(15) Educational or psychological testing—not covered unless part of a treatment program for covered services.

(16) Examinations requested by a third party.

(17) Excessive charges—any otherwise eligible expenses that exceed the maximum allowance or benefit limit.

(18) Exercise equipment.

(19) Experimental services or investigational services—experimental or investigational services, procedures, supplies, or drugs as determined by the claims administrator are not covered, except clinical trials for cancer treatment as specified by law.

(20) Eye glasses and contact lenses—charges incurred in connection with the fitting of eye glasses or contact lenses except for initial placement immediately following cataract surgery.

(21) Eye services—health services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

(22) Services obtained at a government facility—not covered if care is provided without charge.

(23) Hair analysis, wigs, and hair transplants—services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also, hairstyling wigs, hairpieces, and hair prostheses, including those ordered by a participating provider, are not covered. Such items and services are not covered except for members ages eighteen (18) and under with alopecia as specified by law. Subject to two hundred dollar ($200) annual maximum and three thousand two hundred dollar ($3,200) lifetime maximum.

(24) Health and athletic club membership—including costs of enrollment.

(25) Immunizations requested by third party or for travel.

(26) Infertility—Infertility treatments are limited to in-vivo (intrauterine, intracervical, intravaginal fertilization). Those health services and associated expenses for the treatment of infertility are not covered, including reversal of voluntary sterilization, intracytoplasmic sperm injection (ICSI), *in vitro* fertilization, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT) procedures; embryo transport; donor sperm and related cost for collection; no cryopreservation of sperm or eggs; and non-medically necessary amniocentesis.

(27) Level of care, if greater than is needed for the treatment of the illness or injury.

(28) Medical care and supplies—not to the extent that they are payable under—

(A) A plan or program operated by a national government or one of its agencies; or

(B) Any state's cash sickness or similar law including any group insurance policy approved under such law.

(29) Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the subscriber, such as a spouse, parent, child, sibling, or brother/sister-in-law.

(30) Military service connected injury or illness.

(31) Non-network providers—subject to deductible and non-network coinsurance.

(32) Not medically necessary services—with the exception of preventive services.

(33) Obesity—medical and surgical intervention is not covered, unless the member meets the definition of severe morbid obesity as defined in 22 CSR 10-3.010 and satisfies all requirements described in the plan. Bariatric surgery will only be covered when prior authorization is received from the medical plan.

(A) Bariatric surgery additional qualifying criteria—

1. Presence of severe morbid obesity that has persisted for at least five (5) years defined as body mass index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions will be considered based on clinical review;

2. Member must be eighteen (18) years of age or older;

3. Documented evidence of at least two (2) failed attempts at weight loss each with a minimum duration of at least six (6) months with the member achieving at least a ten percent (10%) weight loss and meeting the following additional criteria: one (1) attempt must be in a physician-supervised weight loss program and fully documented in the physician's record; the program must use a multidisciplinary approach including dietician consultation, low-calorie diet, increased physical activity, and behavioral modification; nationally recognized program such as Jenny Craig or Weight Watchers (This does not include self-directed low-calorie diets such as the Atkins Diet or South Beach Diet.); and the most recent attempt must have been within the twelve (12)-month period prior to the requested surgery;

4. Documented evidence the member is on a nutrition and exercise program immediately prior to the surgery request;

5. Evidence the member and the attending physician have a lifelong plan for compliance with lifestyle modification requirements;

6. Documentation the member has completed a psychological evaluation and, if appropriate, behavior modification and should be free of major psychiatric diagnosis or a current behavior which would significantly reduce long-term effectiveness of the proposed treatment; and

7. Procedure must be performed at a Centers of Excellence (COE) facility for Bariatric Surgery as determined by the Centers for Medicare and Medicaid Services.

(B) Network services are limited to one (1) operative procedure for the treatment of obesity per lifetime. Non-network obesity services are not covered.

(C) Revisions and corrections of bariatric procedures only when the revision is used to treat life-threatening complications (e.g. wound infection, abscess, dehiscence, gastric leaking, and embolism). Coverage is limited to the following bariatric procedures: Roux-en-Y Gastric Bypass—open and laparoscopic (RYGBP),

Laparoscopic Adjustable Gastric Banding (LAGB), and Open and Laparoscopic Biliopancreatic Diversion with Duodenal Switch (BPD/DS).

(34) Orthognathic surgery.

(35) Orthoptics.

(36) Other charges—no coverage for charges that would not be incurred if the subscriber was not covered. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan. Miscellaneous service charges—telephone consultations, charges for failure to keep scheduled appointment (unless the scheduled appointment was for a mental health service), or any late payment charge.

(37) Over-the-counter medications—except for insulin through the pharmacy benefit.

(38) Over-the-counter supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings, and support hose.

(39) Physical fitness.

(40) Physical, speech, and occupational therapy—health services and associated expenses for development delay. Treatment for disorders relating to delays in learning, motor skills, and communications.

(41) Private duty nursing.

(42) Prosthetic repair or replacement—not covered unless due to normal wear and tear, if there is a change in medical condition, if growth related, or medically necessary.

(43) Services not specifically included as benefits.

(44) Services rendered after termination of coverage—those services otherwise covered under the agreement, but rendered after the date coverage under the agreement terminates, including services for medical conditions arising prior to the date individual coverage under the agreement terminates.

(45) Stimulators (for bone growth)—not covered unless authorized by claims administrator.

(46) Surrogacy—pregnancy coverage is limited to plan member.

(47) Temporo-Mandibular Joint Syndrome (TMJ).

(48) Third-party examinations.

(49) Tobacco cessation—patches and gum are not covered. There is a limited benefit available under the pharmacy benefit.

(50) Transplants—double listing—payment only for one (1) evaluation up to time of actual transplant.

(51) Transplants—travel expense—requires authorization from medical plan. Limited to ten thousand dollar ($10,000) maximum per transplant when accessing network services.

(52) Transsexual surgery—health services and associated expenses in the transformation operations regardless of any diagnosis or gender role disorientation or psychosexual orientation or any treatment or studies related to sex transformation. Also excludes hormonal support for sex transformation.

(53) Travel expenses—not covered unless authorized by claims administrator.

(54) Trimming of nails, corns, or calluses—not covered except for persons being treated for diabetes, peripheral vascular disease, or blindness.

(55) Usual, Customary, and Reasonable (UCR)—charges exceeding UCR are not covered, as applicable to the non-network benefit.

(56) Vitamins and nutrients—limited to prenatal agents for pregnancy, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents through the pharmacy benefit.

(57) War or insurrection—liability to provide services limited in the event of a major disaster, epidemic, riot, or other circumstances beyond the control of the plan.

(58) Workers' compensation—charges for services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other legislation of similar program.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.090 Pharmacy Benefit Summary

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Pharmacy Benefit Summary for Copay Plan, PPO 300 Plan, PPO 500 Plan, PPO 1000 Plan, and PPO 2000 Plan of the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the*

circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.

(1) The pharmacy benefit provides coverage for prescription drugs, as described in the following:

(A) Medications.

1. Network:

A. Generic: Eight dollar ($8) copayment for up to a thirty (30)-day supply for generic drug on the formulary;

B. Formulary brand: Thirty-five dollar ($35) copayment for up to a thirty (30)-day supply for brand drug on the formulary;

C. Non-formulary: Fifty-five dollar ($55) copayment for up to a thirty (30)-day supply for non-formulary drug;

D. Prescriptions filled with a formulary brand drug when there is a Food and Drug Administration (FDA)-approved generic will be subject to the generic copayment amount in addition to paying the difference between the cost of the generic and the formulary brand drug;

E. Mail order program—

(I) Prescriptions may be filled through the mail order program and the member will receive up to a ninety (90)-day supply for two and one-half (2 ½) regular copayments.

(II) Specialty drugs covered only through network mail order for up to thirty (30) days. Copayments:

(a) Generic: six dollars and sixty-seven cents ($6.67);

(b) Formulary brand: twenty-nine dollars and seventeen cents ($29.17); and

(c) Non-formulary: forty-five dollars and eighty-three cents ($45.83).

2. Non-network pharmacies—If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable copayment. All such claims must be filed within twelve (12) months of the incurred expense.

3. Retail prescription drugs—Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.

(2) If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug rather than the copayment.

(3) Retail and mail order coverage includes the following (except for specialty drugs):

(A) Diabetic supplies, including:

1. Insulin;
2. Syringes;
3. Test strips;
4. Lancets; and
5. Glucometers;

(B) Prescribed vitamins, excluding those vitamins that may be purchased over-the-counter;

(C) Prescribed self-injectables;

(D) Oral chemotherapy agents;

(E) Hematopoietic stimulants;

(F) Growth hormones with prior authorization;

(G) Infertility drugs—subject to fifty percent (50%) member coinsurance; and

(H) Tobacco cessation prescriptions—subject to formulary restrictions and limited to five hundred dollar ($500) annual benefit.

(4) Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. This program involves the member's physician and is only for members who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a first step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first step drug, the physician may request a prior authorization from the pharmacy plan administrator. If the prior authorization is approved, the member is responsible for the applicable copayment which may be higher than the first step drug. If the requested prior authorization is not approved, then the member is responsible for the full price of the drug.

(A) First Step—

1. Uses primarily generic drugs;
2. Lowest applicable copayment is charged; and
3. First step drugs must be used before the plan will authorize payment for second step drugs.

(B) Second Step—

1. This step applies if the member's treatment plan requires a different medication after attempting the first step medication;
2. Uses primarily brand-name drugs; and
3. Typically, a higher copayment amount is applicable.

(5) Prior Authorization—Certain medications are subject to prior authorization. Network pharmacies will notify the member if prior authorization is required. The member or the pharmacy must contact the pharmacy plan administrator before payment will be approved.

(6) Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. Members may request claim forms from the plan or the pharmacy plan administrator. In order to file a claim, members must—

(A) Complete the claim form; and

(B) Attach a prescription receipt or label with the claim form. Patient history printouts from the pharmacy are acceptable but must be signed by the pharmacist. Cash register receipts are not acceptable for any prescriptions, except diabetic supplies. If attaching a receipt or label, the receipt or label shall include—

1. Pharmacy name and address;
2. Patient's name;
3. Price;
4. Date filled;
5. Drug name, strength, and national drug code (NDC);
6. Prescription number;
7. Quantity; and
8. Days supply.

(7) Formulary—The formulary does not change during a calendar year, unless—

(A) A generic drug becomes available to replace the brand-name drug. If this occurs, the generic copayment applies; or

(B) A drug becomes available over-the-counter. If this occurs, then the drug is no longer covered under the pharmacy benefit; and

(C) A drug is determined to have a safety issue.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*

The Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo Supp. 2009.

EXECUTIVE ORDER
09-28

WHEREAS, Missouri has produced some of the most outstanding poets and writers of our time, including Samuel Clemens, Ernest Hemingway, T.S. Eliot, Langston Hughes, Tennessee Williams, Maya Angelou, and Laura Ingalls Wilder; and

WHEREAS, our poets, and their poetry, help define our humanity, and have contributed immeasurably to the culture of our state, the nation, and the world; and

WHEREAS, an awareness and appreciation of poetry increases literacy, creativity, and advanced communication skills; and

WHEREAS, a great poem is capable of lifting our spirits, healing old wounds, creating bonds that last, and bridging any divide.

NOW, THEREFORE, I, JEREMIAH W. (JAY) NIXON, GOVERNOR OF THE STATE OF MISSOURI, by virtue of the authority vested in me by the Constitution and the laws of the state of Missouri, do hereby establish the post of Missouri Poet Laureate.

The Poet Laureate shall be named in January, 2010, and biennially thereafter, and shall serve for two years, at the pleasure of the Governor. In addition to other criteria established, the Poet Laureate must be a published poet, a resident of Missouri, be active in the poetry community, and be willing and able to promote poetry in the state of Missouri throughout the two-year term. The Poet Laureate shall be responsible for promoting the arts in Missouri by making public appearances at public libraries and schools across the state. The Poet Laureate shall also compose an original poem in honor of Missouri that may be used for publication and distribution.

The Poet Laureate shall be selected by the Governor from open nominations solicited from across the state. The Missouri Poet Laureate Advisory Committee is hereby created and established, and shall be comprised of three members of the Missouri Center for the Book and two members appointed by the Governor. The Advisory Committee shall meet as necessary to assist in soliciting, publicizing, and encouraging nominations; to recommend appropriate additional criteria for the nomination process and for the post; to review and evaluate nominees; and to make recommendations to the Governor for appointment to the post of Missouri Poet Laureate. All members of the Advisory Committee shall have expertise in contemporary American poetry, and shall serve at the pleasure of the Governor.

Following the Governor's selection of a Poet Laureate in January of 2010, the Advisory Committee shall next meet in September, 2011 to begin work on the nomination process for the succeeding Poet Laureate, and shall convene for such purpose thereafter every other year.

Executive Order 08-01 is hereby superseded and replaced by this Executive Order.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 24th day of December, 2009.

Jeremiah W. (Jay) Nixon
Governor

ATTEST:

Robin Carnahan
Secretary of State

EXECUTIVE ORDER
09-29

WHEREAS, the state of Missouri experiences emergencies due to tornadoes, rain, snow, flood and ice as well as other unforeseen events requiring motor carriers to transport and distribute fuel, equipment and other essential goods to communities across the state; and

WHEREAS, the safety and welfare of the residents of affected areas may require the rapid identification of an emergency situation that necessitates the need to suspend state enforcement of federal commercial vehicle and driver laws; and

WHEREAS, Section 390.23 of Title 49, Code of Federal Regulations, provides that a Governor of a state, or the Governor's authorized representatives having authority to declare emergencies, may declare an emergency thereby exempting motor carriers or drivers operating a commercial vehicle from the Federal Motor Carrier Safety Regulations, Parts 390-399, both while providing assistance to the relief efforts during the emergency and while returning empty to the motor carrier's terminal or driver's normal work-reporting location; and

WHEREAS, it is imperative that the State's response to emergency situations involve the seamless coordination between numerous state agencies; and

WHEREAS, the State Emergency Management Agency within the Department of Public Safety is tasked with coordinating the State's response efforts during emergencies; and

WHEREAS, a coordinated and efficient analysis and response to situations requiring an emergency declaration exempting motor carriers and drivers operating a commercial vehicle from the Federal Motor Carrier Safety Regulations and relevant state regulations is best provided by designating the Director of the Department of Public Safety as the Governor's authorized representative to declare such emergencies.

NOW THEREFORE, I, JEREMIAH W. (JAY) NIXON, GOVERNOR OF THE STATE OF MISSOURI, by virtue of the authority vested in me by the Constitution and laws of the State of Missouri, do hereby order as follows:

1. The Director of the Missouri Department of Public Safety or the Director's designee is authorized to issue an emergency declaration of a regional emergency within the meaning of 49 CFR section 390.23(a)(1) or a local emergency within the meaning of 49 CFR section 390.23(a)(2) for the limited purpose of temporarily suspending the usual requirements of Parts 390-399 of Title 49, Code of Federal Regulations, with reference to motor carriers and operators of commercial motor vehicles, when such official determines that an emergency situation exists which requires the suspension of federal commercial motor vehicle and driver laws. An emergency declaration issued pursuant to this order shall not exceed the duration of the motor carrier's or driver's direct assistance in providing emergency relief, or five days from the date of the initial declaration of the emergency, whichever is less; and

2. The Missouri Department of Transportation will provide all necessary assistance to the Missouri Department of Public Safety in the assessment of relevant motor carrier and commercial motor vehicle requirements that should be waived pursuant to an emergency declaration; and

3. The Director of the Missouri Department of Public Safety or the Director's designee shall notify the Governor's office as soon as possible of any emergency declarations issued pursuant to this Executive Order; and

4. In order to facilitate an orderly implementation of this Executive Order, the provisions of Executive Order 07-01 as extended by Executive Order 08-40 shall remain in effect until February 1, 2010 at which time they will be superseded by the provisions of this Executive Order.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 31st day of December, 2009.

Jeremiah W. (Jay) Nixon
Governor

ATTEST:

Robin Carnahan
Secretary of State

Under this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

Entirely new rules are printed without any special symbology under the heading of the proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

An important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment, or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

If an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register.* If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

An agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety (90)-day-count necessary for the filing of the order of rulemaking.

If an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

Proposed Amendment Text Reminder:
Boldface text indicates new matter.
[Bracketed text indicates matter being deleted.]

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 3—Filing and Reporting Requirements

PROPOSED AMENDMENT

4 CSR 240-3.190 Reporting Requirements for Electric Utilities and Rural Electric Cooperatives. The commission is amending the purpose and sections (1)–(4), adding a new section (5), renumbering and amending sections (5)–(7), and renumbering sections (8) and (9).

PURPOSE: This amendment will allow the commission to be better informed about electrical accidents and events that result in significant property loss, injury, or death. In particular, the amendment will require electric utilities and rural electric cooperatives to notify the commission of accidents and events involving human contact with electric current of significant voltage even when the utility or cooperative believes the problem originated on the customer's side of the meter.

*PURPOSE: This rule prescribes requirements and procedures for the reporting of certain events by electric utilities to the commission to inform the commission of developments [which] **that** may affect the rendering of safe and adequate service and to enable the commission to thoroughly and fairly investigate **certain accidents and** events[, which] **that** may have an impact in future electric rate proceedings at the time and in the context in which those events occur. This rule also includes electrical facilities [incident] **accident and event** reporting requirements for **rural** electric cooperatives.*

(1) Commencing on September 1, 1991, every electric utility shall accumulate the following information and *[transmit]* **submit** it to the manager of the Energy Department of the commission, or his/her designee, no later than the last business day of the month following the month to be reported and after that on a monthly basis:

(A) All generating unit outages and derates, excluding hydroelectric generating units and units whose capacity comprises less than one and one-half percent (1 1/2%) of the electric utilities *[installed]* **accredited** capacity;

[(B) All fuel purchases for power production purposes, including the terms of those purchases. A copy of the Monthly Report of Cost and Quality of Fuels for Electric Plants on FERC Form No. 423, as submitted to the Federal Energy Regulatory Commission (FERC), will satisfy the requirements of this subsection;]

*[(C)]***(B)** Monthly as-burned fuel report for each carbon-based fuel generating unit, including the amount of each type of fuel consumed, the British thermal unit (Btu) value of each fuel consumed, and the blending percentages (if applicable);

*[(D)]***(C)** Net system input for the electric utility;

*[(E)]***(D)** Net hourly generation for each generating unit;

*[(F)]***(E)** Megawatt amount and delivery prices of hourly purchases and sales of electricity from or to other electrical services providers, independent power producers**,** or cogenerators, including the parties to purchases and sales, and the terms of purchases and sales;

1. If adjustments are made to the price of hourly purchases after the purchase is made, provide the amount of the adjustment and the time period over which the adjustment was made;

*[(G)]***(F)** Capacity purchases of longer than seven (7) days' duration;

*[(H)]***(G)** Planned outages of power production facilities, as they are scheduled or rescheduled. Changes from the planned outage schedule must be reported by telephone or electronic transmission to the manager of the Energy Department of the commission or his/her designee prior to the initiation of the outage, if the changes result in the planned outage schedule being different from the schedule in the most recently submitted monthly report;

*[(I)]***(H)** Planned fuel test burns, unit heat-rate tests**,** and accreditation runs as they are scheduled or rescheduled. Changes from previously planned fuel test burns, unit heat-rate tests**,** and accreditation runs must be reported by telephone or electronic transmission to the manager of the Energy Department of the commission or his/her designee prior to their initiation, if these changes result in the schedule for fuel test burns, unit heat-rate tests**,** and accreditation runs being different from the schedule in the most recently submitted monthly report;

*[(J)]***(I)** Citations or notices of violation related to power production facilities received from any state or federal utility regulatory agency or environmental agency including, but not limited to, the **Federal Energy Regulatory Commission (**FERC**)**, the Nuclear Regulatory Commission (NRC), the Environmental Protection Agency (EPA), the Department of Natural Resources (DNR)**,** and the

Department of Energy (DOE);

*[(K)]***(J)** The terms of new contracts or existing contracts which will be booked to Accounts 310–346 or Accounts 502–546 of the FERC's Uniform System of Accounts requiring the expenditure by the electric utility of more than one hundred thousand dollars ($100,000) including, but not limited to, contracts for engineering, consulting, repairs**,** and modifications or additions to an electric plant; and

*[(L)]***(K)** Copies of all written reports on forced generating unit outages of longer than three (3) days, test burns of fuel, heat-rate tests, accreditation runs**,** and responses to state or federal utility regulatory agencies or environmental agencies including, but not limited to, the FERC, the NRC, the EPA, the DNR**,** and the DOE, concerning any alleged infractions, deviations**,** or noncompliance with those agencies' rules or standards related to power production facilities.

(2) *[Any of t]***T**he information required in **sub**sections (1)**(A) through (I)** of this rule *[may]* **shall** be provided to the manager of the Energy Department of the commission or his/her designee in **an** electronic format **from which the data can be easily extracted for analyses in spreadsheet or database software**. *[The electronic files]* **All the information required in section (1)** may be submitted through the commission's Electronic Filing and Information System (EFIS).

(3) Every electric utility shall report to the manager of the Energy Department of the commission or his/her designee by telephone or through EFIS by the end of the first business day following discovery, the information described in subsections (3)(A)–(E) below. The electric utility shall submit, either by mail or through EFIS within five (5) business days following the discovery, an update of the incident and any details not available at the time of the initial report:

(A) Details of any accident **or event** at a power plant involving serious physical injury or death or property damage in excess of *[one]* **two** hundred thousand dollars *[($100,000)]* **($200,000). A detailed investigative report of the accident or event shall be submitted within ninety (90) days, or if the investigation will take longer than ninety (90) days, a draft of the plan for the investigation shall be submitted within ninety (90) days**;

(C) Forced outages of any fossil-fuel fired generating unit(s) *[which constitutes twenty percent (20%) or more of the electric utility's]* **with an** accredited capacity **of greater than one hundred (100) megawatts** that reasonably could be anticipated to last longer than three (3) days, when the unit(s) is forced out due to a common occurrence;

(4) Every electric utility and rural electric cooperative *[report to the manager of the Energy Department of the commission or his/her designee,]* **shall notify designated commission personnel** by telephone *[or through EFIS, a brief description]* of an accident **or event** by the end of the first business day following the discovery of any accident *[resulting from electrical contact with its energized electrical supply facilities which results in admission to a hospital or the fatality of an employee or other person or any other accident resulting from electrical contact considered significant by the utility. The electric utility or rural electric cooperative shall submit, either by mail or through EFIS within five (5) business days following the discovery, an update of the incident and any details not available at the time of the initial report.]* **or event. Accidents or events that shall be reported shall be those resulting from:**

(A) Electrical contact, arc, or flash with its energized electrical supply facilities that results in admission to a hospital or the fatality of an employee or other person;

(B) Human contact with electric current of significant voltage within areas where it supplies power or operates energized electrical supply facilities that results in admission to a hospital or the fatality of an employee or other person, even when the source of the problem is believed to have originated on the customer's side of the meter, provided the utility or rural electric cooperative first has received proper notice or has actual knowledge of the accident or event; or

(C) Any other accident or event resulting from electrical contact, arc, or flash considered significant by the utility or rural electric cooperative.

(5) The electric utility or rural electric cooperative shall submit to designated commission personnel within five (5) business days following the discovery a written report consisting of an update of the accident or event and any details not available at the time of the initial telephone notification.

*[(5)]***(6)** All reports and information submitted by electric utilities and rural electric cooperatives pursuant to this rule shall be subscribed by the president, treasurer, general manager, receiver**,** or other authorized representative of the electric utility or rural electric cooperative having knowledge of the subject matter and shall be stated to be accurate and complete, and contain no material misrepresentations or omissions, based upon facts of which the person subscribing the report or information has knowledge, information**,** or belief. *[Any information submitted through EFIS will bear the electronic signature of the utility representative who is submitting it.]*

*[(6)]***(7)** The reporting requirements prescribed by this rule shall be in addition to all other reporting requirements prescribed by law.

*[(7)]***(8)** The information contained in the reports filed pursuant to this rule shall be subject to the provisions of section 386.480, RSMo**,** and the use of that information in any proceeding before the commission shall be governed by the terms of **4 CSR 240-2.135 and** any protective order issued by the commission in the proceeding, if a protective order has been issued.

*[(8)]***(9)** The receipt by the commission or commission staff of reports prescribed by this rule shall not bind the commission or commission staff to the approval or acceptance of, or agreement with**,** any matter contained in the reports for the purpose of fixing rates or in determining any other issue that may come before the commission.

*[(9)]***(10)** Upon proper application and after notice and an opportunity for hearing, the commission, in its discretion, may waive any provision of this rule for good cause shown.

AUTHORITY: sections 386.250 and 394.160, RSMo 2000. Original rule filed Aug. 16, 2002, effective April 30, 2003. Amended: Filed Oct. 14, 2003, effective April 30, 2004. Amended: Filed Dec. 16, 2009.

PUBLIC COST: This proposed amendment will not cost affected state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost affected private entities more than five hundred dollars ($500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file comments in support of or in opposition to this proposed amendment with the Missouri Public Service Commission, Steven C. Reed, Secretary of the Commission, PO Box 360, Jefferson City, MO 65102. To be considered, comments must be received at the commission's offices on or before March 5, 2010, and should include a reference to Commission Case No. EX-2010-0122. Comments may also be submitted via a filing using the commission's electronic filing and information system (EFIS). A public hearing regarding this proposed amendment is scheduled for March 8, 2010, at 2:00 p.m. at the commission's offices in the Governor Office Building, 200 Madison Street, Room 305, Jefferson City, Missouri.

Interested persons may appear at this hearing to submit additional comments and/or testimony in support of or in opposition to this proposed amendment and may be asked to respond to commission questions.

SPECIAL NEEDS: Any persons with special needs as addressed by the Americans with Disabilities Act should contact the Missouri Public Service Commission at least ten (10) days prior to the hearing at one (1) of the following numbers: Consumer Services Hotline 1-800-392-4211 (voice) or Relay Missouri at 711.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 3—Filing and Reporting Requirements

PROPOSED AMENDMENT

4 CSR 240-3.545 Filing Requirements for Telecommunications Company Tariffs. The commission is amending section (16); deleting sections (18), (19), and (21); renumbering sections (20) and (23); and renumbering and amending section (22).

PURPOSE: This amendment clarifies certain effective dates and other administrative procedures for proposed tariff revisions consistent with recent changes in the law.

(16) Requirements For Tariff Filings *[Pursuant to Section 392.500, RSMo]* **That Change Rates For Services**.

(A) The commission shall be notified at least ten (10) days in advance of a proposed increase in **individual** rates or charges or a proposed change in any classification or tariff resulting in an increase in rates or charges for competitive telecommunications services. **Commission notice shall be in the form of a tariff filing with a proposed effective date that is at least ten (10) days after the tariff has been filed. Potentially affected customers shall be notified at least ten (10) days prior to the rate increase.**

[1. A proposed increase in rates or charges or a proposed change in any classification or tariff resulting in an increase in rates or charges pursuant to section 392.500 is defined as a rate increase to existing rates or charges for any competitive service.

2. No other tariff changes, except as directed by commission order or as allowed under section (19) below, are permitted on ten (10) day's notice.

3. Commission notice shall be in the form of a tariff filing with a proposed effective date that is ten (10) days after the tariff has been filed.]

(B) The commission shall be notified at least one (1) day in advance of a proposed decrease in **individual** rates or charges or a proposed change in any classification or tariff resulting in a decrease in rates or charges for competitive telecommunications services. **Commission notice shall be in the form of a tariff filing with a proposed effective date that is at least one (1) day after the tariff has been filed.**

[1. A proposed decrease in rates or charges or a proposed change in any classification or tariff resulting in a decrease in rates or charges pursuant to section 392.500 is defined as:

A. A rate decrease to existing rates or charges for any competitive service;

B. A proposal to establish or revise a package of services involving a regulated intrastate service provided all regulated intrastate telecommunications services in the package are currently tariffed on an individual basis.

2. No other tariff changes, except as directed by commission order, are permitted on one (1) day's notice.

3. Commission notice shall be in the form of a tariff filing with a proposed effective date that is one (1) day after the tariff has been filed.

(C) A thirty (30)-day tariff filing is required to introduce or revise the terms and conditions of any competitive service available on an individual basis. A thirty (30)-day tariff filing is required to eliminate any package of services.]

(C) The commission shall be notified at least one (1) day in advance of either the introduction of a new package of services (as that term is used in section 392.200.12, RSMo Supp. 2009) or a change is made to an existing package of services. The commission shall be notified at least ten (10) days in advance of the elimination of a package of services. Commission notice shall be in the form of a tariff filing with a proposed effective date consistent with required commission notice.

(D) Promotions are those service offerings that provide a reduction or waiver of a tariffed rate for a limited period of time. New promotions or changes to existing promotions are allowed to go into effect after one (1) day prior notice to the commission. Promotions must be offered under tariff, and prior notification to the commission via a tariff filing is required. Promotions must have established start and end dates and must be offered in a nondiscriminatory manner.

(E) Changes of rates within a previously approved band of rates do not require tariff changes or prior commission notice.

[(18) Except as otherwise provided in this rule, no tariff will be accepted for filing unless it is delivered to the commission free from all charges or claims for postage and allows the full thirty (30) days required by law from date of receipt until effective date requested in the cover letter.]

[(19) Promotions are those service offerings that provide a reduction or waiver of a tariffed rate for a limited period of time. Promotions are allowed to go into effect after seven (7) days prior notice to the commission for competitive services and after ten (10) days prior notice to the commission for noncompetitive services. Promotions must be offered under tariff, and prior notification to the commission via a tariff filing is required. Promotions must have established start and end dates and must be offered in a nondiscriminatory manner.]

*[(20)]***(18)** In the case of a change of name, the telecommunications company shall issue immediately and file with the commission an adoption notice substantially as follows: "The (name of telecommunications company) hereby adopts, ratifies**,** and makes its own, in every respect as if the same had been originally filed by it, all tariffs filed with the Public Service Commission, State of Missouri, by the (name of telecommunications company) prior to (date) or the telecommunications company shall file a new tariff under the new name." Specific requirements for filings regarding company name changes are contained in Chapter 2 of the commission's rules in rule 4 CSR 240-2.060. In addition to filing the items in 4 CSR 240-2.060, applicant must notify its customers at or before the next billing cycle of any name change affecting customer recognition of the company and file a copy of that notice with the adoption notice.

[(21) Tariffs sent for filing should be addressed to Secretary, Public Service Commission, 200 Madison Street, PO Box 360, Jefferson City, MO 65102.]

*[(22)]***(19)** *[Within six (6) months of the effective date of the rule, all]* **All** telecommunications companies shall update the commission's electronic filing system with the current name, address, telephone number**,** and email address for the regulatory contact person within the telecommunications company*[. This information shall be updated in the electronic filing system]* within ten (10) business days of when changes occur.

*[(23)]***(20)** Waivers regarding compliance with the requirements of this rule granted under previously used rule numbers such as 4 CSR 240-30.010(2)(C) will continue in effect unless otherwise ordered by the commission.

AUTHORITY: section 386.250, RSMo 2000. Original rule filed Aug. 16, 2002, effective April 30, 2003. Rescinded and readopted: Filed Jan. 28, 2004, effective Sept. 30, 2004. Amended: Filed May 12, 2006, effective Dec. 30, 2006. Amended: Filed Dec. 16, 2009.

PUBLIC COST: This proposed amendment will not cost affected state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost affected private entities more than five hundred dollars ($500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file comments in support of or in opposition to this proposed amendment with the Missouri Public Service Commission, Steve Reed, Secretary of the Commission, PO Box 360, Jefferson City, MO 65102. To be considered, comments must be received at the commission's offices on or before March 5, 2010, and should include a reference to Commission File No. TX-2010-0159. Comments may also be submitted via a filing using the commission's electronic filing and information system (EFIS). A public hearing regarding this proposed amendment is scheduled for March 8, 2010, at 10:00 a.m. in the commission's offices in the Governor Office Building, 200 Madison Street, Room 305, Jefferson City, Missouri. Interested persons may appear at this hearing to submit additional comments and/or testimony in support of or in opposition to this proposed amendment and may be asked to respond to commission questions.

SPECIAL NEEDS: Any persons with special needs as addressed by the Americans with Disabilities Act should contact the Missouri Public Service Commission at least ten (10) days prior to the hearing at one (1) of the following numbers: Consumer Services Hotline 1-800-392-4211 (voice) or Relay Missouri at 711.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 33—Service and Billing Practices for Telecommunications Companies

PROPOSED AMENDMENT

4 CSR 240-33.160 Customer Proprietary Network Information. The commission is amending subsection (7)(F).

PURPOSE: This amendment alters and clarifies the filing compliance requirement.

(7) Safeguards Required for Use of Customer Proprietary Network Information.

(F) A *[telecommunications company shall have an officer, as an agent of the company, sign and file with the commission a compliance certificate on an annual basis. The officer shall state in the certification that he or she has personal knowledge that the company has established operating procedures that are adequate to ensure compliance with the rules in this section. The]* company shall *[provide a]* **annually submit** statements *[accompanying the certificate]* **in its annual report to the commission** explaining how its operating procedures ensure that it is or is not in compliance with the rules in this section. **Such statements will be in a format as described in the commission's annual report form. Alternatively, a company may attach to its annual report a copy of its CPNI filing to the Federal Communications Commission if the company does not share CPNI with joint venture partners or independent contractors (except for billing and collection services). If a company does share such CPNI with joint venture partners or independent contractors, then the company must indicate whether confidentiality agreements are used that comply with 4 CSR 240-33.160(3)(A).** In addition, the company shall include an explanation of any actions taken against any individual or entity that unlawfully obtains, uses, discloses, or sells CPNI and a summary of all customer complaints received in the past year concerning the unauthorized release of CPNI. *[This filing must be made annually with the commission on or before March 1, for data pertaining to the previous calendar year.]*

*AUTHORITY: sections 386.040, 386.250, 392.185(9), **and** 392.470, RSMo 2000. Original rule filed March 30, 2004, effective Nov. 30, 2004. Amended: Filed Jan. 25, 2008, effective Sept. 30, 2008. Amended: Filed Dec. 16, 2009.*

PUBLIC COST: This proposed amendment will not cost affected state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost affected private entities more than five hundred dollars ($500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file comments in support of or in opposition to this proposed amendment with the Missouri Public Service Commission, Steve Reed, Secretary of the Commission, PO Box 360, Jefferson City, MO 65102. To be considered, comments must be received at the commission's offices on or before March 5, 2010, and should include a reference to Commission File No. TX-2010-0160. Comments may also be submitted via a filing using the commission's electronic filing and information system (EFIS). A public hearing regarding this proposed amendment is scheduled for March 8, 2010, at 9:00 a.m. in the commission's offices in the Governor Office Building, 200 Madison Street, Room 305, Jefferson City, Missouri. Interested persons may appear at this hearing to submit additional comments and/or testimony in support of or in opposition to this proposed amendment and may be asked to respond to commission questions.

SPECIAL NEEDS: Any persons with special needs as addressed by the Americans with Disabilities Act should contact the Missouri Public Service Commission at least ten (10) days prior to the hearing at one (1) of the following numbers: Consumer Services Hotline 1-800-392-4211 (voice) or Relay Missouri at 711.

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 50—Division of School Improvement
Chapter 270—Early Childhood Education

PROPOSED AMENDMENT

5 CSR 50-270.010 General Provisions Governing Programs Authorized Under the Early Childhood Development Act. The State Board of Education is proposing to amend subsection (1)(B) and the incorporated by reference material.

PURPOSE: This rule establishes policies and standards to administer a program of grants to local public school districts for the provision of early childhood screening, parent education, and programs for developmentally delayed children. Revisions to the administrative

guidelines include changes to the program structure, reimbursement, and recruitment plan.

(1) All programs and projects carried out by school districts under the Early Childhood Development Act (ECDA) shall be conducted in conformity with:

(B) The state "Early Childhood Development Act Program Guidelines and Administrative Manual," revised *[January 2008]* **December 2009**, which is incorporated by reference and made a part of this rule as published by the Department of Elementary and Secondary Education (DESE) and is available at the Early Childhood Education Section, 205 Jefferson Street, PO Box 480, Jefferson City, MO 65102-0480*[,]* or on DESE's *[Internet]* **website**. This rule does not incorporate any subsequent amendments or additions. The "Early Childhood Development Act Program Guidelines and Administrative Manual" interprets state statutory requirements for the programs and establishes program management procedures consistent with state law and practice.

*AUTHORITY: sections 178.691–178.699, RSMo 2000 and section 161.092, RSMo Supp. [2007] **2009**. Original rule filed April 4, 1985, effective Sept. 3, 1985. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Jan. 4, 2010.*

PUBLIC COST: This proposed amendment is estimated to cost the Department of Elementary and Secondary Education $30,874,186 for Fiscal Year 2011, with the cost recurring annually over the life of the rule subject to appropriations. (*FY 2011 requested budget amount)*

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Elementary and Secondary Education, ATTN: JoAnne Ralston, Director, Early Childhood Education, PO Box 480, Jefferson City, MO 65102-0480. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. RULE NUMBER

Title:	5 Department of Elementary and Secondary Education
Division:	50 School Improvement
Chapter:	270 Early Childhood Education
Type of Rulemaking:	Proposed Amendment
Rule Number and Name:	5 CSR 50-270.010 General Provisions Governing Programs
Authorized	Under the Early Childhood Development Act

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Elementary and Secondary Education (Reimburse Education Agencies)	$30,874,186* estimated amount for FY2011 with the cost recurring annually over the life of the rule subject to appropriations. (*FY2011 requested budget amount)

III. WORKSHEET

DISTRICT QUOTAS FOR FISCAL YEAR 2011 (2010-2011)

High Needs	0 TO KE (HN)	Contacts	X $60	$14,307,041.00
Non High Needs	0 TO KE (NHN)	Contacts	X $50	$11,705,761.00
Screening	1 TO 3 (S1) 3 TO KE (S3)	Children	X $25	$ 3,027,950.00
Recruitment and Group Meetings		5% of total allocation		$ 1,543,709.00
Incarcerated Parents (IP)				
High Needs	0 TO KE (IPHN)	Contacts	X $ 60	$284,475.00
Group Meetings	0 TO KE (IPGM)	Meetings	X $ 75	$5,250.00

Each school district is provided with a quota based on the previous year's service and the amount of funds appropriated to the program.

High Needs Parent Education for Families with Children Ages Prenatal To Kindergarten Entry (HN)
FY2011 quotas are based on the 46% of the FY2010 allocation. Up to 50% of the Parent Education Services may be used for families with children three to kindergarten entry provided a parent educator certified to use the three to kindergarten entry curriculum delivers the services.

Non High Needs Parent Education for Families with Children Ages Prenatal to Kindergarten Entry (NHN)
FY2011 quotas are based on the 38% of the FY2010 allocation. Up to 50% of the Parent Education Services may be used for families with children three to kindergarten entry provided a parent educator certified to use the three to kindergarten entry curriculum delivers the services.

Screening of Children Ages One and Two (S1)
FY2011 quotas are based on the FY2010 quota.

Screening of Children Ages Three to Kindergarten Entry (S3)
FY2011 quotas are based on the FY2010 quota.

Incarcerated Parent High Needs Parent Education (IPHN)
FY2011 allocation is based on the FY2010 allocation.

Incarcerated Parents Group Meetings (IPGM)
FY2011 quotas are based on 2 group meetings a month for a 12 month period.

IV. ASSUMPTIONS

The rule incorporates by reference *The Early Childhood Development Act Program Guidelines and Administrative Manual.* Aid included under these programs is limited exclusively to school districts. Due to this limitation, the proposed amendment will not require an expenditure of money by or a reduction in income for any person, firm, corporation, association, partnership, proprietorship, or business entity.

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 60—Division of Career Education
Chapter 100—Adult Education

PROPOSED AMENDMENT

5 CSR 60-100.020 Administration of High School Equivalence Program. The State Board of Education is proposing to amend section (1) to comply with changes in compulsory attendance requirements.

PURPOSE: This amendment changes the age that an individual may take the GED to comply with the compulsory age of attendance requirements under section 167.031, RSMo Supp. 2009.

(1) To be eligible to take the General Educational Development (GED) Tests and earn a Missouri High School Equivalence Certificate, a person must be a resident of Missouri (with a Missouri mailing address)*[,]* and meet one (1) of the following requirements:

(A) Be *[eighteen (18)]* **seventeen (17)** years of age or older;

[(B) Be seventeen (17) years of age and withdrawn from school at least six (6) months from the last day of school attendance;]

*[(C)]***(B)** Be currently enrolled in school and qualify as a participant in an approved Missouri Option Program for at-risk youth; *[or]*

*[(D)]***(C)** Be sixteen (16) *[or seventeen (17)]* years of age, withdrawn from school**,** *[and]* **have successfully completed sixteen (16) units of credit toward high school graduation, and have written permission from the superintendent or principal of the school last attended; or**

[1. Have the written permission of the superintendent or principal of the school last attended;

2. Have written permission of the parent or legal guardian, if home schooled; or

3. Be incarcerated or have the written permission of the juvenile judge if under the court's jurisdiction.]

(D) If home schooled—be sixteen (16) years of age, have met the requirements of section 167.031, RSMo, for course instruction, and have written permission of the parent or legal guardian.

AUTHORITY: sections 161.092 ***and 167.031,*** *RSMo Supp. [2007]* ***2009*** *and sections 161.093 and 161.095, RSMo 2000. Original rule filed Oct. 10, 1969, effective Oct. 20, 1969. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed Jan. 4, 2010.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Elementary and Secondary Education, Attention: Don Eisinger, Coordinator, Adult Education and Employment Training, Division of Career Education, PO Box 480, Jefferson City, MO 65102-0480. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 4—Definitions

PROPOSED RESCISSION

10 CSR 70-4.010 Definitions. This rule provided a legal description of terms used throughout Division 70.

PURPOSE: This rule is being rescinded and readopted due to the large number of changes and new definitions being proposed.

AUTHORITY: Chapter 278, RSMo 1986. Original rule filed Aug. 12, 1980, effective Jan. 1, 1981. Amended: Filed Dec. 14, 1982, effective April 11, 1983. Rescinded: Filed Jan. 4, 2010.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Natural Resources, Bryan Hopkins, Director, Soil and Water Conservation Program, PO Box 176, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 4—Definitions

PROPOSED RULE

10 CSR 70-4.010 Definitions

PURPOSE: This rule provides a legal description of terms used throughout Division 70.

(1) Definitions. As used in these rules, unless the context otherwise requires—

(A) Act shall mean The Soil and Water Conservation Districts Law established pursuant to sections 278.060 to 278.155, RSMo;

(B) Agricultural activity shall mean any uses of land on farms for the production and sale of agricultural products that include, but are not limited to, agricultural crops, hay, livestock, poultry, or wood products. Agricultural activity shall not mean uses associated with recreational, residential, or publicly-owned areas;

(C) Allocated funds shall mean the Soil and Water Conservation Incentives Program (program) funds assigned by the Soil and Water Districts Commission (commission) for use pursuant to the act, but shall not mean funds obligated through contracts between soil and water conservation district boards of supervisors and landowners or operators;

(D) Certified technician shall mean a properly authorized Natural Resources Conservation Service (NRCS), Missouri Department of Conservation (MDC), or Missouri Department of Natural Resources (DNR) employee or a soil and water conservation district (district) employee that has received certification through a commission-approved program for planning, designing, installing, or implementing specific conservation practices;

(E) Commission policy shall mean the decisions promulgated by the commission at regularly-scheduled commission meetings. In the event that more than one (1) commission decision has been promulgated for the same issue, the most recent decision shall represent commission policy;

(F) Commission representative shall mean an entity, agent, or person authorized to act on behalf of the commission in the performance of its duties pursuant to the act. Commission representatives may include, but are not limited to: DNR, districts, NRCS, MDC, and

the Office of Administration;

(G) Conflict of interest shall mean any situation in which the decisions of a public official may be influenced by their personal interests or relationships;

(H) Conservation plan shall mean a written record of the objectives of an individual landowner or a group of landowners regarding planned land use and treatment within the identified farm units of the plan for the protection of soil and water resources. A conservation plan shall be developed in cooperation with the districts where the farm units are located and include a description of the locations and schedules for installing or implementing the conservation practices;

(I) Conservation practice, or practice, shall mean any structural or land management practice designed for the purpose of saving the soil and protecting the water resources of the state and implemented and maintained according to standards and specifications approved by the commission;

(J) Department of Natural Resources, or DNR, shall mean the state agency in Missouri that administers the rules, policies, and programs of the commission and provides assistance, training, and support to the districts;

(K) District board of supervisors, or district board, shall mean the local governing body of a soil and water conservation district, elected or appointed pursuant to the act;

(L) Eligible practice shall mean a conservation practice designated as eligible for state financial incentives by the commission pursuant to 10 CSR 70-5.020(1);

(M) Estimated approved costs shall mean the fair and reasonable costs for labor, materials, and equipment, as determined by the commission, that are minimum and necessary for installing or implementing eligible conservation practices with funds available through the program;

(N) Egress shall mean the right or permission to exit from a property. The right of egress is often a contract condition associated with the inspection, certification, and operation and maintenance of conservation practices;

(O) Farm shall mean land that is assigned a Farm Services Agency (FSA) farm number and three (3) acres or more in size on which agriculture activities are normally performed or land of any size from which one thousand dollars ($1,000) or more of agriculture products are normally sold in a year;

(P) Farm Services Agency, or FSA, shall mean the federal agency in Missouri that maintains records of farm units, landowners, and operators and provides financial incentives for conservation practices through a voluntary partnership with the districts, NRCS, and private landowners;

(Q) Financial incentives shall mean the cost-share and incentive payments available to landowners or operators for installing structural practices and implementing changes to land management techniques;

(R) Gully erosion shall mean the erosion of soil from a narrow channel that is caused by the runoff of water during or immediately after heavy rainfall or snow melt. The distinction between a gully and a rill is depth. A gully is generally an obstacle to farm machinery and is too deep to be smoothed by normal tillage operations; whereas, a rill is of lesser depth and can be smoothed by normal farm tillage;

(S) Ingress shall mean the right or permission to enter a property. The right of ingress is often a contract condition associated with the inspection, certification, and operation and maintenance of conservation practices;

(T) Land representative shall mean the landowner, or a representative of the landowner authorized by a power-of-attorney, of any farm located within an area proposed to be established, and subsequently established, as a soil and water conservation district pursuant to the act. Each farm shall be entitled to representation by a land representative, provided, however, that any land representative must be a taxpayer of the county within which the district is located;

(U) Landowner shall mean any person, firm, or corporation holding title to any lands located within a district organized or to be organized pursuant to the act. Any landowner may be represented by a notarized proxy not more than one (1) year old;

(V) Maintenance life span shall mean a period of ten (10) years or the expected life of a conservation practice as determined by the commission, whichever is less, during which a landowner or operator is required to maintain the effectiveness of the practice;

(W) Missouri Department of Conservation, or MDC, shall mean the state agency in Missouri that certifies conservation practices and provides engineering, technical assistance, and design expertise to private landowners;

(X) Natural Resources Conservation Service, or NRCS, shall mean the federal agency in Missouri that certifies conservation practices, develops standards and specifications for practices, and provides financial and technical assistance for conservation practices through a voluntary partnership with the districts and private landowners and operators;

(Y) Needs assessment shall mean the process approved by the commission for prioritizing resource concerns in participating districts for the purpose of allocating or obligating state funds for the installation or implementation of conservation practices;

(Z) Obligated funds shall mean program funds committed through contracts between district boards and landowners or operators;

(AA) Operator shall mean the principal person that runs a farm by conducting or supervising the work, making day-to-day management decisions, and incurring expenses for applying or installing conservation practices. The operator could be a landowner, tenant, lessee, or sublessee. In the case of multiple operators, the landowner shall identify the principal farm operator and only that person shall be eligible to enter into contracts for implementing and maintaining conservation practices available to operators. In addition, if the operator is not the landowner, the operator must be authorized by a commission-approved landowner authorization form and listed with FSA as the operator of the applicable farm unit. Any operator may be represented by a notarized proxy not more than one (1) year old;

(BB) Participating district shall mean a soil and water conservation district that has executed a Memorandum of Understanding with the commission pursuant to 10 CSR 70-5.010(1);

(CC) Resource concern shall mean a problem area within a farm unit that is eroding above tolerable soil loss, has active gully erosion, or is impacting water resources. Resource concerns are treated by eligible practices as approved by the commission for each resource concern category. Resource concern categories may include, but are not limited to: sheet, rill, and gully erosion; woodland erosion; irrigation management; animal waste management; sensitive areas; nutrient and pest management; and grazing management;

(DD) Soil and water conservation district, or district, shall mean a county or one (1) or more of its townships that has been established as a soil and water conservation district pursuant to the act. If the district boundaries are less than the area of the county which contains it, but greater than the area of one (1) township, the additional township or townships included in the district need not be contiguous with the first township or with one another, but there shall be only one (1) soil and water conservation district within the boundaries of the same county;

(EE) Soil and water conservation incentive funds shall mean funds available through the program;

(FF) Soil and Water Conservation Incentives Program, or program, shall mean the Soil and Water Conservation Cost-Share Program established pursuant to the act and designed for the purpose of saving the soil and protecting the water resources of the state to preserve the productive power of Missouri agricultural land;

(GG) Soil and Water Districts Commission, or commission, shall mean the agency created by section 278.080, RSMo, for the administration of the soil and water conservation districts pursuant to the act;

(HH) Tolerable soil loss shall mean the maximum annual rate of soil loss in tons per acre that can be tolerated on a particular soil and

still permit the productive and sustainable use of soil resources; and

(II) Working day shall mean Monday through Friday except for observed holidays.

AUTHORITY: sections 278.070 and 278.080, RSMo Supp. 2009, section 278.110, RSMo 2000, and Chapter 278, RSMo 2000 and Supp. 2009. Original rule filed Aug. 12, 1980, effective Jan. 1, 1981. Amended: Filed Dec. 14, 1982, effective April 11, 1983. Rescinded and readopted: Filed Jan. 4, 2010.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Department of Natural Resources, Bryan Hopkins, Director, Soil and Water Conservation Program, PO Box 176, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 5—State Funded Cost-Share Program

PROPOSED RESCISSION

10 CSR 70-5.010 Apportionment of Funds. This rule established commission guidelines for allocation of funds available for the Missouri State Soil and Water Conservation Cost-Share Program.

PURPOSE: This rule is being rescinded and readopted due to the large number of changes being proposed.

AUTHORITY: sections 278.070 and 278.110, RSMo 2000 and section 278.080, RSMo Supp. 2007. Original rule filed Aug. 12, 1980, effective Jan. 1, 1981. Amended: Filed Sept. 26, 2007, effective May 30, 2008. Emergency amendment filed July 29, 2009, effective Aug. 8, 2009, expires Feb. 25, 2010. Rescinded: Filed Jan. 4, 2010.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Natural Resources, Bryan Hopkins, Director, Soil and Water Conservation Program, PO Box 176, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 5—Soil and Water Conservation Incentives Program

PROPOSED RULE

10 CSR 70-5.010 Allocation of Funds

PURPOSE: This rule establishes commission procedures for the allocation of program funds.

(1) General Availability of Funds. State funds shall be available only to landowners or operators of land located in soil and water conservation districts which have agreed to locally administer the program and have executed a Memorandum of Understanding with the commission setting forth the terms of assistance. To be eligible for state funds, a landowner or operator must obtain approval of a conservation plan for land owned or under their control. However, an approved conservation plan does not ensure that financial incentives will be provided to a landowner or operator.

(2) Annual Allocation of Funds. Funds available to the program for any fiscal year shall be allocated by the commission to participating districts by considering the district needs assessments according to criteria developed by the commission for saving the soil and protecting the water resources of the state.

(A) Fiscal Year Limitations. Funds allocated to the districts, but unobligated at the end of any fiscal year, shall be reallocated by the commission.

(B) Release of Funds for Reallocation. A district board may, at any time, provide written notice to the commission that it is releasing funds for reallocation by the commission that it does not expect to obligate before the end of the fiscal year.

(C) Termination of the Memorandum of Understanding. In the event that the Memorandum of Understanding required by 10 CSR 70-5.010(1) is terminated by any district board or by the commission, all funds unobligated by the district board as of the effective date of termination shall be reallocated by the commission.

(D) Use of Unobligated or Released Funds. Funds unobligated or released by any district board pursuant to 10 CSR 70-5.010(2)(A)–(C) shall be reallocated by the commission to other districts based on the district needs assessments or reserved by the commission for special allocations under 10 CSR 70-5.010(2)(E).

(E) Special Allocations. The commission may withhold funds from the annual allocations under 10 CSR 70-5.010(2) and may reserve funds released by the districts under 10 CSR 70-5.010(2)(A)–(C) for the purpose of allocating funds to districts for special projects pursuant to 10 CSR 70-5.020(7) which the commission considers necessary and of high importance for saving the soil and protecting the water resources of the state.

AUTHORITY: sections 278.070 and 278.080, RSMo Supp. 2009 and section 278.110, RSMo 2000. Original rule filed Aug. 12, 1980, effective Jan. 1, 1981. Amended: Filed Sept. 26, 2007, effective May 30, 2008. Emergency amendment filed July 29, 2009, effective Aug. 8, 2009, expires Feb. 25, 2010. Rescinded and readopted: Filed Jan. 4, 2010.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Department of Natural Resources, Bryan Hopkins, Director, Soil and Water Conservation Program, PO Box 176, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 5—State Funded Cost-Share Program

PROPOSED RESCISSION

10 CSR 70-5.040 Cost-Share Rates and Reimbursement Procedures. This rule established cost-share rates and reimbursement procedures.

PURPOSE: This rule is being rescinded and readopted due to the large number of changes being proposed.

*AUTHORITY: section 278.080, RSMo Supp. 2007. Original rule filed Aug. 12, 1980, effective Jan. 1, 1981. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed July 29, 2009, effective Aug. 8, 2009, expires Feb. 25, 2010. Rescinded: Filed Jan. 4, 2010.*

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Natural Resources, Bryan Hopkins, Director, Soil and Water Conservation Program, PO Box 176, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 5—Soil and Water Conservation Incentives Program

PROPOSED RULE

10 CSR 70-5.040 Contract Payment Rates and Requests

PURPOSE: This rule establishes the procedures for contract payment rates and requests.

(1) Contract Payment Rates. Contract payment rates for the statewide installation or implementation of eligible practices shall not exceed seventy-five percent (75%) of the estimated approved costs or the incentive rates or contract payment limitations established by the commission for resource concern categories or individual practices. However, the commission shall have authority to establish special contract payment rates of up to one hundred percent (100%) of the estimated approved costs, special incentive rates, and contract payment limitations in defined critical areas for: new practices pursuant to 10 CSR 70-5.060(5); special allocations pursuant to 10 CSR 70-5.010(2)(E); special projects pursuant to 10 CSR 70-5.020(7); and priority practices, which the commission considers necessary and of high importance for saving the soil and protecting the water resources of the state.

(2) Contract Payment Requests. After an eligible practice has been installed or implemented by the landowner or operator and certified by a certified technician, the landowner or operator may submit a contract payment request on commission-approved forms provided by the district. Landowners or operators shall submit the necessary forms and receipts as required by commission policy with each contract payment request.

*AUTHORITY: sections 278.070 and 278.080, RSMo Supp. 2009. Original rule filed Aug. 12, 1980, effective Jan. 1, 1981. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed July 29, 2009, effective Aug. 8, 2009, expires Feb. 25, 2010. Rescinded and readopted: Filed Jan. 4, 2010.*

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Department of Natural Resources, Bryan Hopkins, Director, Soil and Water Conservation Program, PO Box 176, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 5—State Funded Cost-Share Program

PROPOSED RESCISSION

10 CSR 70-5.050 District Administration of the Cost-Share Program. This rule established guidelines for the administration of the Cost-Share Program by the participating districts.

PURPOSE: This rule is being rescinded and readopted due to the large number of changes being proposed.

*AUTHORITY: sections 278.070, 278.080, and 278.110, RSMo 1986. Original rule filed Aug. 12, 1980, effective Jan. 1, 1981. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed July 29, 2009, effective Aug. 8, 2009, expires Feb. 25, 2010. Rescinded: Filed Jan. 4, 2010.*

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Natural Resources, Bryan Hopkins, Director, Soil and Water Conservation Program, PO Box 176, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 5—Soil and Water Conservation Incentives Program

PROPOSED RULE

10 CSR 70-5.050 District Administration of the Program

PURPOSE: This rule establishes procedures for the administration of the program by the participating districts.

(1) District Board Action on Contracts. The district board of each

participating district shall approve or disapprove each contract and contract change order. The action shall be recorded in the official minutes of the next available district board meeting, and the landowners or operators shall be notified of the action within ten (10) working days. If the contract is approved, the district board shall, at the same time, notify the landowner or operator of the contract payment amount determined pursuant to 10 CSR 70-5.020(4). Special circumstances may arise where district board approval for a contract, contract change order, or contract payment request is appropriate and needed before the next monthly district board meeting. In these cases, the district board shall establish specific criteria for delegating authority to approve that action by a district board member or subcommittee. All such approvals shall be reviewed at the next district board meeting and recorded in the official minutes of that meeting. Contracts may be approved by the district board only when there is a sufficient unobligated fund balance to provide the estimated amount based upon the actual cost information available to the district board. The district board shall not approve any contract in which the installation or implementation of the practice has already begun.

(2) Denial of Contracts by the District Board. The district board of each participating district shall have authority to deny any contract for participation in any program available through the district and administered by the commission. The district board shall notify the landowner or operator of the denial by certified letter, return receipt requested. The landowner or operator may request that the commission conduct a review of his or her contract. The request shall be in writing and mailed to the Soil and Water Districts Commission, PO Box 176, Jefferson City, MO 65102. The request must be received by the commission no later than thirty (30) days from the date the landowner or operator received the denial letter from the district board. If the written request is received by the commission within the thirty (30)-day timeframe, the commission shall schedule a review of the contract at a regularly scheduled meeting of the commission within one hundred twenty (120) days of the district board's denial. The commission shall give the landowner or operator at least twenty (20)-days' notice by letter of the regularly scheduled meeting when the commission will review the contract. The landowner or operator, upon request, may appear before the commission and provide justification for approval of the contract in person, by a representative, or in writing.

(3) District Review of Contract Payment Requests. Upon completion of an eligible practice, the district shall review the contract payment request prepared by the landowner or operator on commission-approved forms pursuant to 10 CSR 70-5.040(2). If the district finds that the practice was installed or implemented properly, and the contract payment request is complete, accurate, and accompanied by all required supporting documentation, then the district board shall approve the contract payment request. If the district determines that the contract payment request is prepared improperly, or that other deficiencies exist, it shall so notify the landowner or operator and provide the landowner or operator with a reasonable opportunity to correct the deficiencies and resubmit the contract payment request.

(4) Contract Violations. If the district becomes aware of an alleged contract violation, a district representative shall investigate the alleged violation and report the results of the investigation to the district board.

(A) If the district board determines that a violation has occurred, it shall notify the landowner or operator of the violation by certified letter, return receipt requested, and require the landowner or operator to correct the problem at his or her own expense within a reasonable and fair period of time.

(B) If the violation is not corrected by the specified period of time, the district board shall notify the landowner or operator by a second certified letter, return receipt requested, that he or she remains in violation of their contract and identify the actions that will be taken by the district board or required of the landowner or operator.

1. If the contract violation is unrelated to the removal, alteration, or modification of the practice, the district board shall notify the landowner or operator that the matter is being referred to the commission for further action.

2. If the practice has been removed, altered, or modified so as to lessen its effectiveness during the maintenance life span of the practice, without prior approval of the district board, the district board shall notify the landowner or operator, or his or her heirs, assignees, or other transferees, of the amount that must be refunded to the program within thirty (30) days after receipt of the district board's letter.

A. The amount to be repaid shall be based on the prorated amount of the payment previously received for the practice or the portion of the practice that has been removed, altered, or modified.

B. If the payment is not received by the district board within thirty (30) days, the matter shall be referred to the commission for further action.

(5) District Assistance to Landowners or Operators. The district shall provide assistance to landowners or operators in completing any commission-approved forms and with any other program matters.

(6) Record Keeping. The district shall maintain records of the funds obligated for conservation practices, program expenditures, and other information, as required by commission policy, using software provided by a commission representative.

(7) Filing System. To provide for efficient processing of requests for contract payments and maintenance of necessary documentation related to the administration of the program, the district shall develop and maintain a filing system which includes copies of all forms completed by the landowner or operator and all other information considered applicable to the installation or implementation of the eligible practices and the financial incentives provided. The files shall be available for inspection by a commission representative or representatives of the state auditor's office during normal business hours of the district.

(8) Delegation of Responsibilities by the District Board. The district board may delegate the following responsibilities to a district board member or subcommittee of the district board:

(A) Approval or denial of contracts;

(B) Approval or denial of contract change orders;

(C) Approval of contract payment requests; or

(D) Any other responsibilities assigned to district boards, except the following which may not be delegated by the district board:

1. Development of an annual priority list of preferred practices;

2. Determination of special contract payment rates;

3. Recording of maintenance agreements and the rights of ingress and egress;

4. Assumption of all or a portion of the operation and maintenance responsibilities for landowners or operators;

5. Determination of contract violations; and

6. Approval or denial of requests for removing, altering, or modifying practices; and

(E) Any approvals or denials of contracts, contract change orders, or contract payment requests by a district board member or a subcommittee of the district board shall be discussed and approved at the next available district board meeting.

(9) Conflicts of Interest. District board members shall not vote on or use any delegated authority to approve or deny any contracts, contract change orders, or contract payment requests for themselves, any relatives by blood or marriage, or any other person in which they have a conflict of interest.

AUTHORITY: sections 278.070 and 278.080, RSMo Supp. 2009 and section 278.110, RSMo 2000. Original rule filed Aug. 12, 1980,

*effective Jan. 1, 1981. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed July 29, 2009, effective Aug. 8, 2009, expires Feb. 25, 2010. Rescinded and readopted: Filed Jan. 4, 2010.*

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Department of Natural Resources, Bryan Hopkins, Director, Soil and Water Conservation Program, PO Box 176, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 5—State Funded Cost-Share Program

PROPOSED RESCISSION

10 CSR 70-5.060 Commission Administration of the Cost-Share Program. This rule established guidelines for the administration of the Cost-Share Program by the commission.

PURPOSE: This rule is being rescinded and readopted due to the large number of changes being proposed.

*AUTHORITY: sections 278.070(4), 278.080(8), and 278.110.8, RSMo Supp. 1995. Original rule filed Aug. 12, 1980, effective Jan. 1, 1981. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed July 29, 2009, effective Aug. 8, 2009, expires Feb. 25, 2010. Rescinded: Filed Jan. 4, 2010.*

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Natural Resources, Bryan Hopkins, Director, Soil and Water Conservation Program, PO Box 176, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 5—Soil and Water Conservation Incentives Program

PROPOSED RULE

10 CSR 70-5.060 Commission Administration of the Program

PURPOSE: This rule establishes procedures for the administration of the program by the commission and its representatives.

(1) Forms and Guidance Documents. A commission representative shall prepare and make available to participating districts all commission-approved forms necessary for district administration. A commission representative shall also prepare and update, as necessary, guidance documents such as handbooks and training manuals for district use in assisting the commission with administration of the program.

(2) Review of Contract Payment Requests. Upon receipt of a district board-approved contract payment request on an appropriate commission-approved form, a commission representative shall review the request and supporting documentation. If the request is determined to be complete and accurate, a commission representative shall provide payment to the landowner or operator.

(3) Incomplete or Inaccurate Contract Payment Requests. If a commission representative determines that the information contained in the contract payment request is incomplete or inaccurate, the district shall be notified of the deficiencies. The district shall then request the necessary corrections from the landowner or operator. No payment shall be authorized until the commission representative has determined that the contract payment request and supporting documentation are complete and accurate. Contract payment conditions (e.g., maintenance agreements, rights of ingress and egress), as determined by the district board, shall not be recorded in the county until the payment has been authorized by the commission representative and received by the landowner or operator.

(4) Contract Violations. If the commission becomes aware of an alleged contract violation, a commission representative shall investigate the alleged violation and report the results of the investigation to the commission and the district board.

(A) If the district board determines that a violation has occurred, it shall notify the landowner or operator of the violation by certified letter, return receipt requested, and require the landowner or operator to correct the violation at his or her own expense within a reasonable and fair period of time.

(B) If the violation is not corrected by the specified period of time, the district board shall notify the landowner or operator by a second certified letter, return receipt requested, that he or she remains in violation of their contract and identify the actions that will be taken by the district board or required of the landowner or operator.

1. If the violation is unrelated to the removal, alteration, or modification of the practice, the district board shall notify the landowner or operator that the matter is being referred to the commission for further action.

2. If the practice has been removed, altered, or modified so as to lessen its effectiveness during the maintenance life span of the practice without prior approval of the district board, the district board shall notify the landowner or operator, or his or her heirs, assignees, or other transferees, of the amount that must be repaid to the program within thirty (30) days after receipt of the district board's second certified letter.

A. The amount to be repaid shall be based on the prorated amount of the payment previously received for the practice or the portion of the practice that has been removed, altered, or modified.

B. If the repayment is not received by the district board within thirty (30) days, the matter shall be referred to the commission for further action.

C. Within thirty (30) days after receiving the second certified letter from the district board, the landowner or operator may dispute the district board's judgment by making a written request to the commission that they review the evidence regarding the district board's decision. The written request shall be mailed to the Soil and Water Districts Commission, PO Box 176, Jefferson City, MO 65102.

D. If the written request is received by the commission within the thirty (30)-day timeframe:

(I) The commission shall schedule the review of the violation at a regularly scheduled meeting of the commission within one hundred twenty (120) days of the district board's denial.

(II) A commission representative shall give the landowner

or operator at least twenty (20)-days' notice by letter of the regularly scheduled meeting when the commission will review the violation.

(III) The landowner or operator, upon request, may appear before the commission and provide justification for his or her actions in person, by a representative, or in writing.

(IV) If the commission determines that no violation has occurred or that extenuating circumstances justify the landowner's or operator's actions, the district board's requirement for repayment shall be withdrawn, and a commission representative shall so notify the landowner or operator of its decision by certified letter, return receipt requested.

(V) If, however, the commission determines that the violation did occur, a commission representative shall so notify the landowner or operator by certified letter, return receipt requested, that repayment is required within thirty (30) days after receipt of the commission representative's letter.

(C) If the required repayment is not received from the landowner or operator within thirty (30) days after receipt of the commission representative's letter or if all contract violations have not been corrected at the landowner's or operator's expense within the time specified by the commission, the commission may refer the matter to the Office of the Attorney General for further action.

(5) New Practices. The commission shall have authority to conduct a pilot project for the purpose of testing the development and implementation of new practices appropriate for future soil and water conservation resource needs. Any pilot project shall be conducted for a specified period of time within a defined critical area determined by the commission.

AUTHORITY: sections 278.070 and 278.080, RSMo Supp. 2009 and section 278.110, RSMo 2000. Original rule filed Aug. 12, 1980, effective Jan. 1, 1981. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed July 29, 2009, effective Aug. 8, 2009, expires Feb. 25, 2010. Rescinded and readopted: Filed Jan. 4, 2010.*

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Department of Natural Resources, Bryan Hopkins, Director, Soil and Water Conservation Program, PO Box 176, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 30—State Tax Commission
Chapter 3—Local Assessment of Property and Appeals From Local Boards of Equalization

PROPOSED AMENDMENT

12 CSR 30-3.010 Appeals From the Local Board of Equalization. The commission is amending subsection (1)(B).

PURPOSE: This amendment will allow new property owners the chance to appeal the assessment of their property when the prior owner was not notified of an increase or when there is insufficient time to appeal to the board of property after the property is transferred.

(1) Every owner of real property or tangible personal property shall have the right to appeal from the decision of the local board of equalization, upon compliance with the following rules:

(B) A complaint appealing a property assessment shall be filed not later than September 30 or within thirty (30) days of the decision of the board of equalization, whichever is later.

1. In any county or the City of St. Louis**, the owner may appeal directly to the State Tax Commission (a)** where the assessor fails to notify the **current** owner of the property*[, or the predecessor in title or interest,]* of an initial assessment or an increase in assessment from the previous year, prior to **thirty (30) days before** the deadline for filing an appeal to the board of equalization, *[the owner may appeal directly to the State Tax Commission]* **including instances in which real property was transferred and the prior owner was notified, or (b) where a new owner purchased real property less than thirty (30) days before the deadline for filing an appeal to the board of equalization or later in the tax year, regardless if the assessment is an initial assessment, an increase or decrease in assessment, or an assessment established in the prior year**. Appeals under this paragraph shall be filed within thirty (30) days after a county official mailed a tax statement or otherwise first communicated the assessment or the amount of taxes to the owner or on or before December 31 of the tax year in question, whichever is later. Proof of late notice**, the date of purchase, and/or notice sent to the prior owner** shall be attached to, or set forth in, the complaint.

2. A property owner who, due to lack of notice, files an appeal directly with the State Tax Commission after tax statements are mailed shall pay his or her taxes under protest pursuant to the requirements of section 139.031*[.1]*, RSMo, and the county collector shall upon receiving either the payment under protest or the notice specified in section *[140.430]* **138.430**, RSMo, impound all portions of taxes which are in dispute. Payment of taxes without a section 139.031*[.1]*, RSMo, protest and prior to the time when the State Tax Commission's notice under section 138.430.4, RSMo, is received by the county collector*[,]* will result in disbursal of taxes and dismissal of complainant's appeal;

AUTHORITY: section 138.430, RSMo Supp. 2009. This rule was previously filed as 12 CSR 30-2.030. Original rule filed Dec. 13, 1983, effective March 12, 1984. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed Dec. 21, 2009.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Sandy Wankum, Administrative Secretary, State Tax Commission, PO Box 146, Jefferson City, MO 65102, (573) 751-2414. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 30—State Tax Commission
Chapter 3—Local Assessment of Property and Appeals From Local Boards of Equalization

PROPOSED AMENDMENT

12 CSR 30-3.025 Collateral Estoppel. The commission is amending this rule by deleting section (5).

PURPOSE: This amendment cleans up the rule since the section being deleted will be incorporated into another rule.

[(5) A taxpayer who acquires title to or interest in property after the close of the board of equalization appeal hearings may not appeal to the commission for that tax year if the predecessor in title or interest had not appealed to the board of equalization for the year in which the transfer occurred. If the predecessor in title or interest had appealed to the board of equalization, and if such predecessor or successor in title or interest timely filed an appeal to the commission which is still active at the time of transfer of title or interest, the successor in title or interest may then complete the appeal process for that tax year before the commission. If the predecessor in title or interest litigated the issue of assessed valuation of the subject property in the odd-numbered year, the successor in title or interest to the same property may not lodge an appeal in the following even-numbered year for the same property unless there has been new construction or improvements as defined in 12 CSR 30-3.001.]

*AUTHORITY: sections 138.320, 138.431, and 138.432, RSMo [1994] **2000** and **sections** 137.115 and 138.430, RSMo Supp. [1999] **2009**. Original rule filed May 14, 1991, effective Oct. 31, 1991. Amended: Filed July 19, 2000, effective Feb. 28, 2001. Amended: Filed Dec. 21, 2009.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Sandy Wankum, Administrative Secretary, State Tax Commission, PO Box 146, Jefferson City, MO 65102, (573) 751-2414. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 30—State Tax Commission
Chapter 4—Agricultural Land Productive Values

PROPOSED AMENDMENT

12 CSR 30-4.010 Agricultural Land Productive Values. The commission is amending this rule to adjust agricultural land values.

PURPOSE: This rule complies with the requirement of section 137.021, RSMo, to publish a range of productive values for agricultural and horticultural land for the ensuing tax year.

(1) Agricultural Land Grades and Values. The following are definitions of agricultural land grades and the productive values of each:

(A) Grade #1. This is prime agricultural land. Condition of soils is highly favorable with no limitations that restrict their use. Soils are deep, nearly level (zero to two percent (0–2%) slope) or gently sloping with low erosion hazard and not subject to damaging overflow. Soils that are consistently wet and poorly drained are not placed in Grade #1. They are easily worked and produce dependable crop yields with ordinary management practices to maintain productivity—both soil fertility and soil structure. They are adapted to a wide variety of crops and suited for intensive cropping. Use value: *[nine hundred eighty-five dollars ($985)]* **one thousand two hundred seventy dollars ($1,270)**;

(B) Grade #2. These soils are less desirable in one (1) or more respects than Grade #1 and require careful soil management, including some conservation practices on upland to prevent deterioration. This grade has a wide range of soils and minimum slopes (mostly zero to five percent (0–5%)) that result in less choice of either crops or management practices. Primarily bottomland and best upland soils. Limitations—

1. Low to moderate susceptibility to erosion;

2. Rare damaging overflows (once in five to ten (5–10) years); and

3. Wetness correctable by drainage. Use value: *[eight hundred ten dollars ($810)]* **one thousand forty-four dollars ($1,044)**;

(C) Grade #3. Soils have more restrictions than Grade #2. They require good management for best results. Conservation practices are generally more difficult to apply and maintain. Primarily good upland and some bottomland with medium productivity. Limitations—

1. Gentle slope (two to seven percent (2–7%));

2. Moderate susceptibility to erosion;

3. Occasional damaging overflow (once in three to five (3–5) years) of Grades #1 and #2 bottomland; and

4. Some bottomland soils have slow permeability, poor drainage, or both. Use value: *[six hundred fifteen dollars ($615)]* **seven hundred ninety-three dollars ($793)**;

(D) Grade #4. Soils have moderate limitations to cropping that generally require good conservation practices. Crop rotation normally includes some small grain (for example, wheat or oats), hay, or both. Soils have moderately rolling slopes and show evidence of serious erosion. Limitations—

1. Moderate slope (four to ten percent (4–10%));

2. Grade #1 bottomland subject to frequent damaging flooding (more often than once in two (2) years), or Grades #2 and #3 bottomland subject to occasional damaging flooding (once every three to five (3–5) years);

3. Poor drainage in some cases; and

4. Shallow soils, possibly with claypan or hardpan. Use value: *[three hundred eighty-five dollars ($385)]* **four hundred ninety-six dollars ($496)**;

(E) Grade #5. Soils are not suited to continuous cultivation. Crop rotations contain increasing proportions of small grain (for example, wheat or oats), hay, or both. Upland soils have moderate to steep slopes and require conservation practices. Limitations—

1. Moderate to steep slopes (eight to twenty percent (8–20%));

2. Grades #2 and #3 bottomland subject to frequent damaging flooding (more than once in two (2) years) and Grade #4 bottomland subject to occasional damaging flooding; and

3. Serious drainage problems for some soils. Use value: *[one hundred ninety-five dollars ($195)]* **one hundred forty-seven dollars ($147)**;

(F) Grade #6. Soils are generally unsuited for cultivation and are limited largely to pasture and sparse woodland. Limitations—

1. Moderate to steep slopes (eight to twenty percent (8–20%));

2. Severe erosion hazards present;

3. Grades #3 and #4 bottomland subject to frequent damaging flooding (more than once in two (2) years), and Grade #5 bottomland subject to occasional damaging flooding (once every three to five (3–5) years); and

4. Intensive management required for crops. Use value: *[one hundred fifty dollars ($150)]* **one hundred thirteen dollars ($113)**;

(G) Grade #7. These soils are generally unsuited for cultivation and may have other severe limitations for grazing and forestry that cannot be corrected. Limitations—

1. Very steep slopes (over fifteen percent (15%));

2. Severe erosion potential;

3. Grades #5 and #6 bottomland subject to frequent damaging flooding (more than once in two (2) years);

4. Intensive management required to achieve grass or timber productions; and

5. Very shallow topsoil. Use value: *[seventy-five dollars ($75)]* **fifty-seven dollars ($57)**;

(H) Grade #8. Land capable of only limited production of plant growth. It may be extremely dry, rough, steep, stony, sandy, wet or severely eroded. Includes rivers, running branches, dry creek and swamp areas. The lands do provide areas of benefit for wildlife or recreational purposes. Use value: thirty dollars ($30); and

(I) Definitions. The following are definitions of flooding for purposes of this rule:

1. Damaging flooding. A damaging flood is one that limits or affects crop production in one (1) or more of the following ways:

A. Erosion of the soil;

B. Reduced yields due to plant damage caused by standing or flowing water;

C. Reduced crop selection due to extended delays in planting and harvesting; and

D. Soil damage caused by sand and rock being deposited on the land by flood waters;

2. Frequent damaging flooding. Flooding of bottomlands that is so frequent that normal row cropping is affected (reduces row crop selection); and

3. Occasional damaging flooding. Flooding of bottomland that is so infrequent that producing normal row crops is not compromised in most years.

(2) Forest Land and Horticultural Land. The following prescribes the treatment of forest land and horticultural land:

(A) Forest land, whose cover is predominantly trees and other woody vegetation, should not be assigned to a land classification grade based on its productivity for agricultural crops. Forest land of two (2) or more acres in area, which if cleared and used for agricultural crops, would fall into land grades #1–#5 should be placed in land grade #6; or if land would fall into land grades #6 or #7 should be placed in land grade #7. Forest land may or may not be in use for timber production, wildlife management, hunting, other outdoor recreation or similar uses; and

(B) Land utilized for the production of horticultural crops should be assigned to a land classification grade based on productivity of the land if used for agricultural crops. Horticultural crops include fruits, ornamental trees and shrubs, flowers, vegetables, nuts, Christmas trees and similar crops which are produced in orchards, nurseries, gardens or cleared fields.

AUTHORITY: section 137.021, RSMo 2000. Original rule filed Dec. 13, 1983, effective March 12, 1984. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed Dec. 21, 2009.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions forty-six thousand dollars ($46,000) statewide.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Sandy Wankum, Administrative Secretary, State Tax Commission, PO Box 146, Jefferson City, MO 65102, (573) 751-2414. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: Department of Revenue
Division Title: Division 30 State Tax Commission
Chapter Title: Chapter 4 Agricultural Land Productivity Value

Rule Number and Name:	12 CSR-30.4.010 Agricultural Land Productivity Value
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
114 County Assessors	$46,000 statewide

III. WORKSHEET

The cost of updating productivity grade values would be negligible. The cost of generating notices of increased assessments and mailing them to the taxpayers would be very roughly estimated as follows:

- Thirty-five percent of the 655,000 agricultural parcels, or 230,000, would be affected.
- Estimating that the average agricultural taxpayer with land in grades one through four owns three agricultural parcels (or two agricultural parcels and a residential parcel that could receive an increase notice) would reduce the number of impact notices to be mailed to approximately 76,667.
- Estimating the cost to print and mail each notice at $0.60, the total cost statewide would be $46,000.

IV. ASSUMPTIONS

Title 15—ELECTED OFFICIALS
Division 40—State Auditor
Chapter 4—Audits of Fire Protection Districts in St. Louis and Greene Counties

PROPOSED AMENDMENT

15 CSR 40-4.010 Requirements for Districts. The state auditor is amending sections (3) and (4).

PURPOSE: This amendment updates auditing requirements to comply with various provisions of generally accepted government auditing standards.

(3) The district shall require from the independent auditor an engagement letter which sets out all essential particulars. A copy of the engagement letter shall be submitted to the state auditor for his/her review**.** *[before commencement of audit fieldwork. The purpose of this review is to provide reasonable assurance that the district has contractually committed an auditor to provide services to satisfy requirements of 15 CSR 40-4. The contents of this letter should include, but are not limited to:*

(A) Period for which the financial statements are audited;

(B) Purpose of the audit;

(C) Scope of the audit, including consideration of the internal control structure and tests of compliance with applicable laws and regulations;

(D) Provisions that the auditor will communicate, in writing, to the district material weaknesses or reportable conditions in the internal control structure, instances of noncompliance with applicable laws and regulations and other areas of possible improvement;

(E) Provision that all workpapers, etc., will be made available to the state auditor for his/her review upon his/her request;

(F) Provision that the auditor will comply with applicable rules issued by the state auditor under 15 CSR 40;

(G) Provision that the auditor will discuss with the district any factors s/he may discover which would prevent him/her from issuing an unqualified opinion on the financial statements and allow the district and the auditor the opportunity to arrive at a resolution acceptable to both;

(H) Statement of the auditor's responsibility for detection of errors, irregularities and illegal acts; and

(I) The estimated cost of the audit and the rates which are the basis for that estimate.]

(4) The district *[must]* **shall** file a copy of the completed audit report with the state auditor within six (6) months after the close of the audit period. If any audit report fails to comply with promulgated rules, the state auditor *[will]* **shall** notify the district and specify the defects. If the specified defects are not corrected within ninety (90) days from the date of the state auditor's notice to the district, or if a copy of the required audit report has not been received by the state auditor within the specified time, the state auditor *[will]* **shall** make, or cause to be made, the required audit at the expense of the district.

*AUTHORITY: section 321.690, RSMo [Supp. 1993] **2000**. Original rule filed May 12, 1978, effective Sept. 11, 1978. Amended: Filed Dec. 2, 1985, effective Feb. 13, 1986. Amended: Filed June 14, 1994, effective Nov. 30, 1994. Amended: Filed Dec. 17, 2009.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Missouri State Auditor's Office, PO Box 869, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 15—ELECTED OFFICIALS
Division 40—State Auditor
Chapter 4—Audits of Fire Protection Districts in St. Louis and Greene Counties

PROPOSED AMENDMENT

15 CSR 40-4.020 Standards for Auditing and Financial Reporting. The state auditor is amending sections (1), (3), and (4) and deleing section (2).

PURPOSE: This amendment updates auditing requirements to comply with various provisions of generally accepted government auditing standards.

(1) The independent auditor shall meet all requirements of Chapter 326, RSMo*[. The auditor must be able to demonstrate that s/he meets the independence criteria contained in]***, and** the code of professional ethics and rules of conduct promulgated by the Missouri State Board of Accountancy.

[(2) The independent auditor shall provide to the state auditor reasonable notification of any entrance or exit conferences held with the district. This notification shall be sufficiently in advance to allow the state auditor to attend the entrance or exit conference at his/her discretion. Upon request, the independent auditor shall provide a draft copy of the audit report and management letter to the state auditor prior to the exit conference.]

*[(3)]***(2)**The audit shall conform to the standards *[for auditing of governmental organizations, programs, activities and functions as]* **(hereafter referred to as "generally accepted government auditing standards")** established by the *[c]***C**omptroller *[g]***G**eneral of the United States **and applicable to financial audits of government entities, programs, activities, and functions**.

*[(4)]***(3)** The **contents of the** financial *[statements, supplementary data and accompanying notes]* **report** shall be presented in conformity with generally accepted accounting principles.

*AUTHORITY: section 321.690, RSMo [Supp. 1993] **2000**. Original rule filed May 12, 1978, effective Sept. 11, 1978. Amended: Filed Dec. 2, 1985, effective Feb. 13, 1986. Amended: Filed June 14, 1994, effective Nov. 30, 1994. Amended: Filed Dec. 17, 2009.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Missouri State Auditor's Office, PO Box 869, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 15—ELECTED OFFICIALS
Division 40—State Auditor
Chapter 4—Audits of Fire Protection Districts in St. Louis and Greene Counties

PROPOSED AMENDMENT

15 CSR 40-4.030 Contents of Audit Reports. The state auditor is amending sections (2) and (3) and adding section (4).

PURPOSE: This amendment updates auditing requirements to comply with various provisions of generally accepted government auditing standards.

(2) *[All]* **The** audit report*[s]* shall contain:

[(B) A report on the financial statements;]

*[(C)]***(B)** *[Combined]* **The** financial statements and *[appropriate note disclosures;]* **other information required by generally accepted accounting principles; and**

[(D) Other financial information which includes, but is not limited to, the following:

1. Supplemental schedule of expenditures/expenses by object, if not included in the financial statements;

2. Tax rates and assessed valuation;

3. Schedule of insurance in force which shall include, in addition to other information, the agent for each policy; and

4. Principal officeholders who held office during the period under audit, compensation received by each official in performance of his/her duty and all other compensation or reimbursement of expenses made by the district to each officeholder; and]

(C) The auditor's reports required by generally accepted government auditing standards: a report of the financial statements and other financial information and a report on internal control over financial reporting and on compliance and other matters.

[(E) A report on the consideration of the internal control structure, a report on the tests of compliance with applicable laws and regulations and a management letter communicating areas of possible improvement not otherwise reported.] The required scope of audit for the reports *[and management letter]* is set forth in 15 CSR 40-4.040*[(3)]*. The reports *[and management letter]* shall include the findings and recommendations, if any, which the auditor developed during his/her audit and the district's responses to those findings and recommendations. *[The reports and management letter shall also indicate the nature of previous recommendations and the extent to which the district has implemented those recommendations.]*

(3) *[If the district or the auditor deems it appropriate,]* **The** audit report*[s]* may contain or utilize *[the following:]* **a statistical section to include other information**

[(A) A history and organization section prepared by the district (unaudited);

(B) Comparative financial data for one (1) or more years; and

(C) Other statements, exhibits, schedules or analyses as] deemed necessary or appropriate by the district *[or the auditor]*.

(4) As part of, or along with, the audit report, the auditor shall submit a management letter communicating areas of possible improvement not otherwise reported.

*AUTHORITY: section 321.690, RSMo [Supp. 1993] **2000**. Original rule filed May 12, 1978, effective Sept. 11, 1978. Amended: Filed Dec. 2, 1985, effective Feb. 13, 1986. Amended: Filed June 14, 1994, effective Nov. 30, 1994. Amended: Filed Dec. 17, 2009.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Missouri State Auditor's Office, PO Box 869, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 15—ELECTED OFFICIALS
Division 40—State Auditor
Chapter 4—Audits of Fire Protection Districts in St. Louis and Greene Counties

PROPOSED AMENDMENT

15 CSR 40-4.040 Scope of Audit. The state auditor is amending sections (2) and (3) and deleting section (4).

PURPOSE: This amendment updates auditing requirements to comply with various provisions of generally accepted government auditing standards.

(2) The independent auditor shall prepare an engagement letter in accordance with generally accepted government auditing standards. The contents of this letter should include, but are not limited to:

(A) Provision that all audit documentation will be made available to the state auditor for his/her review upon his/her request; and

(B) Provision that the auditor will comply with applicable rules issued by the state auditor under 15 CSR 40.

*[(2)]***(3)** The audit shall include those tests of the accounting records and other audit*[ing]* procedures which the independent auditor considers necessary in the circumstances to conform to *[the]* **generally accepted government auditing** standards**.** *[for auditing of governmental organizations, programs, activities and functions as established by the comptroller general of the United States.]*

*[(3)]***(A)** As part of the audit *[described in section (2)]*, the auditor *[will]* **shall** obtain an understanding of the **district and its environment, including its** internal control *[structure,]* **and** assess *[control]* **the** risk *[and report any material weaknesses or reportable conditions]* **of material misstatement of the financial statements**. The auditor *[will]* **shall** also test compliance with **provisions of** applicable laws**,** *[and]* regulations**,** *[and report all material instances of noncompliance. As a part of, or in addition to, audit tests or procedures which may be necessary for the audit, the auditor shall—]***contracts, and grant agreements.**

[(A) Review systems, procedures and management practices, including:

1. Review cash management practices to the extent necessary to determine whether significant improvements appear practicable and economically justifiable;

2. Evaluate the purchasing function to the extent necessary to determine that the district generally receives fair value, for example, bidding of significant purchases; that purchases generally represent items consistent with the function of the district; and that there is not significant likelihood of misuse or misappropriation of the district's resources through the purchasing process;

3. Review fixed asset records and procedures to the extent necessary to determine that fixed assets are properly recorded, physically controlled and in the possession of the district;

4. Review fidelity bond coverages to determine that all persons with access to assets of the district appear covered in sufficient amounts;

5. Evaluate the budgeting practices to the extent necessary to determine whether significant improvements appear practicable and economically justifiable;

6. Review related party transactions;

7. Review evaluate other areas as required by the district; and

8. Review significant areas or matters which come to the attention of the auditor;

(B) The auditor will note areas of possible improvement in the district's systems, procedures and management practices. In evaluating district systems, procedures and management practices, the auditor should consider whether improvements appear practicable and economically justifiable.

(C) Test compliance with applicable laws and regulations, including:

1. Design the audit to provide reasonable assurance of detecting errors, irregularities and illegal acts that could have a direct and material effect on the financial statements;

2. Be aware of the possibility of illegal acts that could have an indirect and material effect on the financial statements; and

3. Test compliance with other legal provisions as s/he deems necessary or appropriate in the circumstances.]

*[(D)]***(B)** Legal provisions which the auditor should consider in *[his/her]* **the** audit include, but are not limited to*[, the following]*:

1. Article III, Sections 38(a) and 39(3) and Article VI, Section 25, *Constitution of Missouri* limitations on use of funds and credit;

2. Article VI, Section 26, *Constitution of Missouri* limitations on indebtedness without popular vote;

3. Article VI, Section 29, *Constitution of Missouri* application of funds derived from public debts;

4. Article VII, Section 6, *Constitution of Missouri* penalty for nepotism;

5. Chapter 67, RSMo**,** budgetary requirements;

6. Sections 70.210 to 70.230 and *[S]*section 432.070, RSMo**,** contracts;

7. Section 105.145, RSMo**,** annual report;

8. Chapter 105, RSMo**,** conflict of interest;

9. Chapter 108, RSMo**,** bond issues; **and**

10. Chapter 321, RSMo**,** fire protection districts*[;]***.**

[11. Other applicable portions of the Constitution of Missouri and the Missouri Revised Statutes;

12. Applicable sections of Code of State Regulations; and

13. Other applicable legal provisions.]

[(4) The auditor shall report on the reviews and examinations required by this rule in a management letter as set forth in 15 CSR 40-4.030(2)(E).]

*AUTHORITY: section 321.690, RSMo [Supp. 1993] **2000**. Original rule filed May 12, 1978, effective Sept. 11, 1978. Amended: Filed Dec. 2, 1985, effective Feb. 13, 1986. Amended: Filed June 14, 1994, effective Nov. 30, 1994. Amended: Filed Dec. 17, 2009.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Missouri State Auditor's Office, PO Box 869, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 10—The Public School Retirement System of Missouri
Chapter 5—Retirement, Options and Benefits

PROPOSED AMENDMENT

16 CSR 10-5.010 Service Retirement. The Public School Retirement System of Missouri is amending sections (2) and (6).

PURPOSE: This amendment changes the length of the required termination period from sixty (60) to thirty (30) days, changes the manner in which a retiree may be employed by a covered school district during the termination period, implements pro rata limitations on hours worked and earnings allowed, and requires the employer and retiree to keep a log of hours worked and earnings during retirement.

(2) The earliest date on which service retirement may become effective is the first day of the calendar month following the calendar month in which the services of the member are terminated, or the first day of the calendar month following the filing of the Application for Service Retirement, whichever is later; except that the earliest date on which service retirement may become effective for a member retiring after receiving credit for a year of membership service shall be July 1, the first day of the fiscal year following the termination of services. Termination from employment covered by the retirement system prior to the effective date of retirement is required to be eligible for a retirement benefit. A member shall not be deemed to have terminated employment if the member is employed in *[a position]* **any capacity by an employer** covered by the retirement system within *[sixty (60) days]* **one (1) month** after his or her effective date of retirement. A member shall not be deemed to have terminated employment if, prior to receipt of his or her first benefit payment, the member executes a contract for employment in *[a position]* **any capacity by an employer** covered by the retirement system that commences on or after the execution of such contract. The member shall be required to repay any benefit payments paid if it is determined that the member did not terminate employment covered by the retirement system.

(6) Part-time employment is any employment which is less than full-time. Temporary-substitute employment is any employment either in a position held by a regularly employed person who is temporarily absent*[,]* or in a position which is temporarily vacant. A retired member may be employed by a district included in the system to serve on a part-time or temporary-substitute basis in any capacity not to exceed five hundred fifty (550) hours in any one (1) school year and through such employment may earn an amount not in excess of the compensation limit set forth in this rule and section 169.560, RSMo, without a discontinuance of the retired member's retirement allowance. The limit on compensation shall be determined as set forth in section 169.560, RSMo. If the position or positions did not previously exist, a retired member may earn up to fifty percent (50%) of the annual compensation payable for the position within the district that is most comparable to the position filled by the retired member without exceeding the compensation limit. If such employment exceeds either the limitation on hours worked or the limitation on compensation, payment of benefits to the retired member shall cease until the employment terminates or a new school year begins. This rule shall not apply to employment with a state college, a state

university, or any state agency. **The employer covered by the Public School Retirement System of Missouri and the retiree shall maintain a log of all dates worked, hours worked, wage earned, and the employer. The employer and retiree shall provide a copy of the work log upon request of retirement system.**

Employee Name:		School Year:	
Date Worked	Hours Worked	Wage Earned	Employer

The working after retirement limits set forth in section 169.560, RSMo, shall be applied on a pro rata basis as provided below to a retiree's hours of work during the school year in which the retiree's date of retirement is effective.

Effective date of retirement	Hours allowed after retirement for school year
July 1	550
August 1	504
September 1	458
October 1	413
November 1	367
December 1	321
January 1	275
February 1	229
March 1	183
April 1	138
May 1	92
June 1	0

The working after retirement limits set forth in section 169.560, RSMo, shall be applied on a pro rata basis as provided below to a retiree's base salary to determine the retiree's earnings limit during the school year in which the retiree's date of retirement is effective.

Effective date of retirement	Percentage of base salary allowed after retirement for school year
July 1	50%
August 1	46%
September 1	42%
October 1	38%
November 1	33%
December 1	29%
January 1	25%
February 1	21%
March 1	17%
April 1	13%
May 1	8%
June 1	0%

*AUTHORITY: section 169.020, RSMo Supp. [2006] **2009**. Original rule filed Dec. 19, 1975, effective Jan. 1, 1976. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Jan. 4, 2010.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Public School and Education Employee Retirement Systems of Missouri, Attn: Maria Walden, PO Box 268, Jefferson City, Missouri 65102-0268. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 10—The Public School Retirement System of Missouri
Chapter 5—Retirement, Options and Benefits

PROPOSED AMENDMENT

16 CSR 10-5.020 Disability Retirement. The Public School Retirement System of Missouri is amending section (5).

PURPOSE: This amendment will provide the Public School Retirement System of Missouri the ability to require the member to submit to a periodic examination or provide the board of trustees with a completed Certification of Disability Status form for disability retirement as set forth in the method of qualification and limitations as provided in sections 169.060, 169.070, and 169.075, RSMo.

(5) The recipient of disability benefits may be required to submit to periodic examinations until age sixty (60) by physicians selected and paid by the board, provided there shall not be more than two (2) examinations in any year. **If the member fails to submit to a periodic examination or provide the board of trustees with a completed Certification of Disability Status form, the member's disability benefit shall be suspended until such certification of the member's continued disability is received by the board of trustees.**

*AUTHORITY: section 169.020, RSMo Supp. [2005] **2009**. Original rule filed Dec. 19, 1975, effective Jan. 1, 1976. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Jan. 4, 2010.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Public School and Education Employee Retirement Systems of Missouri, Attn: Maria Walden, PO Box 268, Jefferson City, Missouri 65102-0268. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 10—The Public School Retirement System of Missouri
Chapter 6—The Public Education Employee Retirement System of Missouri

PROPOSED AMENDMENT

16 CSR 10-6.060 Service Retirement. The Public Education Employee Retirement System of Missouri is amending sections (1) and (4).

PURPOSE: This amendment changes the length of the required termination period from sixty (60) to thirty (30) days, changes the manner in which a retiree may be employed by a covered school district during the termination period, implements pro rata limitations on hours worked, and requires the employer and retiree to keep a log of hours worked during retirement.

(1) The earliest date on which retirement may become effective is the first day of the calendar month following the calendar month in which the services of the member are terminated, or the first day of the calendar month following the filing of the application for retirement, whichever is later; except that the earliest date on which retirement may become effective for a member who receives a year of membership service credit for the final school year in which the member serves shall be July 1 next following the member's last day of service. Termination from employment covered by the retirement system prior to the effective date of retirement is required to be eligible for a retirement benefit. A member shall not be deemed to have terminated employment if the member is employed in *[a position]* **any capacity by an employer** covered by the retirement system within *[sixty (60) days]* **one (1) month** after his or her effective date of retirement. A member shall not be deemed to have terminated employment if, prior to receipt of his or her first benefit payment, the member executes a contract for employment in *[a position]* **any capacity for an employer** covered by the retirement system that commences on or after the execution of such contract. The member shall be required to repay any benefit payments paid if it is determined that the member did not terminate employment covered by the retirement system.

(4) A retiree may serve as an employee of a district included in the system on a part-time or temporary-substitute basis not to exceed five hundred fifty (550) hours in a school year and continue to receive a retirement allowance. To be considered as serving on a temporary-substitute basis, a person must be serving for a regular employee who is temporarily absent or in a position which is temporarily vacant. **The employer covered by the Public Education Employee Retirement System of Missouri and the retiree shall maintain a log of all dates worked, hours worked, wage earned, and the employer in substantially the same form as provided below. The employer and retiree shall provide a copy of the work log upon request of retirement system.**

Employee Name:		School Year:	
Date Worked	Hours Worked	Wage Earned	Employer

The working after retirement limits set forth in section 169.660.2, RSMo, shall be applied on a pro rata basis as provided below to a retiree's hours of work during the school year in which the retiree's date of retirement is effective.

Effective date of retirement	Hours allowed after retirement for school year
July 1	550
August 1	504
September 1	458
October 1	413
November 1	367
December 1	321
January 1	275
February 1	229
March 1	183
April 1	138
May 1	92
June 1	0

*AUTHORITY: section 169.610, RSMo Supp. [2006] **2009**. Original rule filed Dec. 19, 1975, effective Jan. 1, 1976. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Jan. 4, 2010.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Public School and Education Employee Retirement Systems of Missouri, Attn: Maria Walden, PO Box 268, Jefferson City, Missouri 65102-0268. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 10—The Public School Retirement System of Missouri
Chapter 6—The Public Education Employee Retirement System of Missouri

PROPOSED AMENDMENT

16 CSR 10-6.070 Disability Retirement. The Public Education Employee Retirement System of Missouri is amending sections (1), (2), (4), (5), and (6) and adding new sections (7) and (8).

PURPOSE: This amendment will provide the ability for our members of the Public Education Employee Retirement Systems to have the effective date of disability retirement be retroactive up to sixty (60) days prior to the filing of the application for disability retirement as set forth in the method of qualification and limitations as provided in section 169.663, RSMo. This amendment will also provide the Public Education Employee Retirement Systems the ability to require the member to submit to a periodic examination or provide the board of trustees with a completed Certification of Disability Status form for disability retirement as set forth in the method of qualification and limitations as provided in section 169.663, RSMo.

(1) **A member claiming disability retirement must file a written application for retirement with the board of trustees on a form provided by the board. If a member, because of physical or mental disability, is unable to make application for disability retirement, the written application may be completed by a guardian or trustee designated by a court, and the completed application shall be accompanied by a certified copy of the court order designating the guardian or trustee.** If a member indicates in his/her application for disability retirement (see 16 CSR 10-5.020) that s/he has applied for disability benefits provided by the Social Security Act, the Award Letter or certified copy thereof, issued by the Social Security Administration, will serve as evidence that disability exists.

(2) If a member is not eligible for disability benefits, as provided by the Social Security Act, because of insufficient coverage, the board of trustees*[, acting upon the recommendation of the medical adviser, shall designate one (1) or more physicians for examinations and reports. The medical adviser shall evaluate the reports and shall recommend to the board of trustees. The board shall determine whether or not disability exists.]* **shall designate a medical adviser whose duty shall be to assign applicants for disability benefits to physicians for examinations and reports. The medical advisor shall report to the board on the**

findings of the examining physicians and the board of trustees shall act on these findings. The recipient of disability benefits may be required to submit to periodic examinations until age sixty (60) by physicians selected and paid by the board, provided there shall not be more than two (2) examinations in any year.

(4) If disability shall cease to exist before the recipient of the disability benefits reaches age sixty (60), as evidenced by the cessation of benefits by the Social Security Administration or by examination by physicians selected and paid by the board of trustees, his/her disability benefits shall cease and his/her membership status as of the date of his/her disability retirement shall be restored. **If the member is required to submit to a periodic examination and the member fails to submit to the examination or provide the board of trustees with a completed Certification of Disability Status form, the member's disability benefit shall be suspended until such certification of the member's continued disability is received by the board of trustees.**

(5) *[The earliest date on which a member's disability retirement can become effective is the first day of the calendar month following the month for which his/her last salary payment or sick-leave payment was made, or the first day of the calendar month following the calendar month in which his/her completed application was received, whichever is later.]* **The payment of the first disability benefits to a member shall be made not later than the calendar month immediately following the month in which the claim is approved. The first payment after approval shall include any benefits which have accrued between the date of disability and the date of the first payment, provided, however, that payment shall not be made for such time as the member is receiving any salary from an employer, and provided that benefits shall not accrue for more than sixty (60) days prior to the date of filing application.**

(6) Any person who is receiving a disability retirement allowance from the retirement system and who has attained age sixty (60) may be employed in any capacity for, and receive income of any amount from, any employer except a school district included in the retirement system. Notwithstanding any provision of section 169.660, RSMo**,** to the contrary, any such person may be employed in a district included in the retirement system on a part-time or temporary-substitute basis up to a total of five hundred fifty (550) hours in a school year without a discontinuance of the retirement allowance **as set forth in section 169.660, RSMo, and 16 CSR 10-6.060(4)**.

(7) Any person who is receiving a disability retirement allowance from the retirement system and who has not attained age sixty (60) may not be employed in any capacity by a district included in the retirement system and continue to receive the retirement allowance. Any such person may not be employed in any capacity for any other employer, the compensation for which employment would constitute a livelihood, and continue to receive the retirement allowance. The executive director, and/or the board of trustees, shall determine what constitutes a livelihood in such instance.

(8) The surviving spouse, children of a deceased disability retiree, or both, shall have the same rights to benefits under section 169.670, RSMo, as does the surviving spouse, children, or both, of a member who dies while employed in a district included in the retirement system.

*AUTHORITY: section 169.610, RSMo [1994] **Supp. 2009**. Original rule filed Dec. 19, 1975, effective Jan. 1, 1976. Amended: Filed June 15, 1994, effective Nov. 30, 1994. Amended: Filed Oct. 15, 1997, effective April 30, 1998. Amended: Filed Jan. 4, 2010.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Public School and Education Employee Retirement Systems of Missouri, Attn: Maria Walden, PO Box 268, Jefferson City, Missouri 65102-0268. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.010 Definitions. The Missouri Consolidated Health Care Plan is amending the purpose; deleting sections (2), (7), (8), (10), (64), (66), (79), and (81); renumbering and amending sections (3)–(6), (9), (11)–(63), (65), (67)–(78), (80), and (82)–(92); and adding new sections (6), (9)–(12), (14)–(18), (20), (24), (30), (34), (35), (41), (43), (45)–(47), (49), (50), (53), (59), (60), (64), (69), (70), (72), (76), (80), (82), (83), (99), (101), (102), (104), (106), (108)–(110), (114), (116), (119), (122), (125)–(127), and (130).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the definitions of the Missouri Consolidated Health Care Plan.

*PURPOSE: This rule establishes the policy of the board of trustees [regarding] **in regard to** the [key terms] **definitions** of the Missouri Consolidated Health Care Plan relative to state members.*

[(2) Actively at work. You are considered actively at work when performing in the customary manner all of the regular duties of your occupation with the employer either at one (1) of the employer's regular places of business or at some location which the employer's business requires you to travel to perform your regular duties or other duties assigned by your employer. You are also considered to be actively at work on each day of a regular paid vacation or nonworking day on which you are not totally disabled, but only if you are performing in the customary manner all of the regular duties of your occupation with the employer on the immediately preceding regularly scheduled workday.]

*[(3)]***(2)** Administrative appeal. *[Appeal procedures]* **A written request submitted by or on behalf of a member** involving Missouri Consolidated Health Care Plan (MCHCP) administrative issues such as eligibility, effective date**s** of coverage, **plan changes,** etc.

*[(4)]***(3)** Administrative guidelines. *[The]* **Instructive** interpretation of the plan document *[as approved by the plan administrator,]* developed for administration of the plan. The administrative guidelines may be changed upon approval of the executive director or his/her designee. Benefits provided shall be those in effect at the time services are rendered.

*[(5)]***(4)** Adverse determination. When the claims administrator reviews an admission, availability of care, continued stay**,** or other health care service and decides that it is not medically necessary,

appropriate**,** or effective. Therefore, payment for the requested service is denied, reduced**,** or terminated.

*[(6)]***(5)** Allowable expense. Charges for services rendered or supplies furnished by a health plan that would qualify as covered expenses and for which the program pays in whole or in part, subject to any deductible, coinsurance, or table of allowance included in the program.

[(7) Automatic reinstatement maximum. The maximum annual amount that can be reinstated to an individual's lifetime benefit.

(8) Benefit year. The twelve (12)-month period beginning January 1 and ending December 31. All annual deductibles and benefit maximums accumulate during the benefit year.]

(6) Appeal. A written complaint submitted by or on behalf of a member regarding one (1) of the following:

(A) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or

(B) Claim payment, handling, or reimbursement for pharmacy benefits or health care services.

(7) Benefit period. The three hundred sixty-five (365) days immediately following the first date of like services.

*[(9)]***(8)** Benefits. Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator.

[(10) Care Support Program. A voluntary program that helps manage a chronic condition with outpatient treatment.]

(9) Birthday rule. If both parents have medical coverage, the primary plan for dependent children is the plan of the parent whose birthday occurs first in the calendar year. If birthdays occur on the same day, the parent's coverage that has been in effect longest is primary.

(10) Board. The board of trustees of the Missouri Consolidated Health Care Plan.

(11) Calendar year. The period of time from January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All annual deductibles and benefit maximums accumulate during the calendar year.

(12) Chiropractic services. The examination, diagnosis, adjustment, manipulation, and treatment of malpositioned articulations and structures of the body, directed toward restoring and maintaining the normal neuromuscular and musculoskeletal function and health.

*[(11)]***(13)** Claims administrator. An organization or group responsible for the processing of claims and associated services for the plan's self-insured benefit programs, including but not limited to the preferred provider organization (PPO) (also known as the co*[-]*pay plan) and health maintenance organization (HMO) type plans.

(14) Coinsurance. The shared portion of payment between the plan and the subscriber where each pays a percentage of covered charges.

(15) Comprehensive major medical. A plan that provides for cost sharing to be applied to all covered expenses such as deductible or coinsurance.

(16) Congenital defect. Existing or dating from birth. Acquired through development while in the uterus.

(17) Convenient care clinics (CCCs). Health care clinics located in retail stores, supermarkets, and pharmacies that treat routine family illnesses and provide preventive health care services. They are sometimes referred to as "retail-based clinics" or "walk-in medical clinics." CCCs are usually staffed by nurse practitioners or physician assistants. Some CCCs, however, are staffed by physicians.

(18) Coordination of benefits. Communication, adjustment, and reconciliation procedures between multiple benefit plans covering the same member for purposes of covering services and expenses relating to plan benefits.

*[(12)]***(19)** Co*[-]*pay plan. A set of benefits similar to a health maintenance organization option.

(20) Copayment. A set dollar amount that the covered individual must pay for specific services.

*[(13)]***(21)** Cosmetic surgery. A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than restore the anatomy and/or functions of the body which are lost or impaired due to illness or injury.

*[(14)]***(22)** Covered benefits **and charges**. A schedule of covered services and charges*[, including chiropractic services, which are]* payable under the plan. The benefits covered under each type of plan are outlined in the applicable rule in this chapter.

*[(15)]***(23)** Custodial care. Services and supplies furnished primarily to assist an individual to meet the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a health care provider or that do not entail *[or]* **and** require the continuing attention of trained medical or paramedical personnel.

(24) Date of service. Date medical services are received or performed.

*[(16)]***(25)** Deductible. The amount of expense the member must pay before the plan begins to pay for covered services and supplies. This amount is not reimbursable by the plan.

*[(17)]***(26)** Dependent-only participation. Participation of certain survivors of *[employees]* **subscribers**. Dependent participation may be further defined to include the deceased *[employee's]* **subscriber's**:

(A) Spouse only;

(B) Child(ren) only; or

(C) Spouse and child(ren).

*[(18)]***(27)** Dependents. The lawful spouse of the employee, the employee's unemancipated child(ren)**,** and certain survivors of employees, as provided in the plan document and these rules, for whom application has been made and has been accepted for participation in the plan.

*[(19)]***(28)** Diagnostic charges. The Usual, Customary**,** and Reasonable (UCR) charges or the network discounted rate (NDR) for x-ray or laboratory examinations made or ordered by a physician in order to detect a medical condition.

*[(20)]***(29)** Disposable supplies. **Medical supplies that** *[D]***d**o not withstand prolonged use and are periodically replaced. Includes, but not limited to, colostomy and ureterostomy bags.

(30) Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:

(A) Doctor of medicine;

(B) Doctor of osteopathy;

(C) Podiatrist;

(D) Optometrist;

(E) Chiropractor;

(F) Psychologist;

(G) Doctor of dental surgery; or

(H) Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practice of spiritual healing are well established and recognized.

*[(21)]***(31)** Durable medical equipment (DME). Equipment able to withstand repeated use for the therapeutic treatment of an active illness or injury. Such equipment is not covered under the plan if it could be useful to a person in the absence of an illness or injury and could be purchased without a physician's prescription.

*[(22)]***(32)** Eligibility date. Refer to 22 CSR 10-2.020 for effective date provisions.

(A) Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of employment or reemployment.

(B) Employees transferred from a state department with coverage under another medical care plan into a state department covered by this plan and their eligible dependents who were covered by the other medical care plan *[will be]* **are** eligible for participation *[subject to any applicable pre-existing conditions as outlined in the plan document]* **immediately**.

(C) Employees who terminate all employment with the state (not simply move from one **(1)** agency to another) and are rehired as a new state employee before termination of participation, and their eligible dependents who were covered by the plan, will be eligible for participation immediately.

(D) Employees who terminate all employment with the state (not simply move from one **(1)** agency to another) and are rehired as a new state employee in the subsequent month, and their eligible dependents who were covered by the plan, will be eligible for participation retroactive to the date following termination of participation **or at the employee's choice, on the first day of the month following the employee's date of rehire**.

*[(23)]***(33)** Emancipated child(ren). A child(ren) who is:

(A) Employed on a full-time basis;

(B) Eligible for group health benefits in his/her own behalf;

(C) Maintaining a residence separate from his/her parents or guardian, except for full-time students in an accredited school or institution of higher learning; or

(D) Married.

(34) Emergency. Any medical condition leading a prudent layperson to seek immediate medical attention. This normally means the sudden onset of a health condition that manifests itself by acute symptoms and severity (including severe pain). Examples of medical emergencies include, but are not limited to:

(A) Conditions placing a person's health in significant jeopardy;

(B) Serious impairment to a bodily function;

(C) Serious dysfunction of any bodily organ or part;

(D) Inadequately controlled pain; or

(E) Situations when the health of a pregnant woman or her unborn child are threatened.

(35) Emergency room. The section of a hospital equipped to furnish emergency care to prevent the death or serious impairment of the covered person.

*[(24)]***(36)** Employee and dependent participation. Participation of an employee and the employee's eligible dependents. Any individual eligible for participation as an employee is not eligible as a dependent, except as noted in 22 CSR 10-2.020(1)(A)3. Dependent participation may be further defined to include the participating employee's:

(A) Spouse only;

(B) Child(ren) only; or

(C) Spouse and child(ren).

[(25) Employee only participation. Participation of an employee without participation of the employee's dependents, whether or not the employee has dependents.]

*[(26)]***(37)** Employees. Employees of the state and present and future retirees from state employment who meet the eligibility requirements as prescribed by state law.

*[(27)]***(38)** Employer. The state department **or agency** that employs the eligible employee as defined above.

*[(28)]***(39)** Executive director. The *[administrator]* **chief executive officer** of the Missouri Consolidated Health Care Plan (MCHCP) who *[reports directly to the plan administrator]* **shall have charge of the offices, records, and employees of the plan, subject to the direction of the board**.

*[(29)]***(40)** Experimental/Investigational/Unproven. A treatment, procedure, device**,** or drug that meets any of the criteria listed below is considered experimental/investigational/unproven*[,]* and is not eligible for coverage under the plan. Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community. Experimental/investigational/unproven is defined as a treatment, procedure, device**,** or drug that the plan administrator determines, in the exercise of its discretion:

(A) Has not received the approval of the U.S. Food and Drug Administration for marketing the drug or device at the time it is furnished, if such approval is required by law;

(B) Is shown by reliable evidence to be the subject of ongoing Phase I clinical trials or under study to determine its maximum tolerated dose, its toxicity, **its** safety, **its** efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or

(C) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device**,** or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy**,** or its efficiency as compared with the standard means of treatment or diagnosis.

(41) First eligible. The first thirty-one (31)-day period after a member's employment date in which the member and his/her dependents may enroll in an MCHCP plan. As a member acquires new dependents, his/her first eligible period is the first thirty-one (31) days from the date the dependent meets the eligibility requirements for coverage under the plan.

*[(30)]***(42)** Formulary *[drugs]*. A list of drugs *[preferred]* **covered** by the **pharmacy program** claims administrator *[of the pharmacy program]* and as allowed by the plan administrator.

(43) Generic drug. The chemical equivalent of a brand-name drug with an expired patent. The color or shape may be different, but the active ingredients must be the same for both.

*[(31)]***(44)** Grievance. A written complaint submitted by or on behalf of a member regarding either:

(A) Availability, delivery**,** or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or

(B) Claims payment, handling**,** or reimbursement for health care services.

(45) Group health plan. A plan maintained by an employer or an employee organization to provide medical care or other health services, directly or indirectly, to employees, former employees, and their families, including but not limited to Medicare and Medicaid plans.

(46) Handbook. The summary plan document prepared for members explaining the terms, conditions, and all material aspects of the plan and benefits offered under the plan, a copy of which is incorporated by reference into this rule. The full text of material incorporated by reference will be made available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, 2010 State Member Handbook (January 1, 2010). It does not include any later amendments or additions.

(47) Health assessment. A questionnaire about a member's health and lifestyle habits which qualifies the member for participation in the *Lifestyle Ladder* program to earn the incentive premium.

*[(32)]***(48)** Health maintenance organization (HMO). A plan that provides for a wide range of comprehensive health care services for a specified group at a fixed periodic prepayment.

(49) Health savings account (HSA). A tax-advantaged savings account that may be used to pay current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA. HSA funds can be used to help pay the deductible, coinsurance, and any qualified medical expenses not covered by the health plan.

(50) High Deductible Health Plan (HDHP). A health plan with higher deductibles than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

*[(33)]***(51)** Home health agency. An agency certified by **Medicare and** the Missouri Department of Health and Senior Services, or any other state's licensing or certifying body, to provide health care services to persons in their homes.

*[(34)]***(52)** Hospice. *[A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill.]* **A public agency, private organization, or a subdivision of either that primarily engages in providing care to terminally ill individuals, meets the conditions of participation for hospices, holds a valid Medicare provider agreement, and is licensed pursuant to state law.**

(53) Hospice facility. A public or private organization, certified by Medicare and any other state's licensing or certifying body, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill. The facility must have an interdisciplinary medical team consisting of at least one (1) physician, one (1) registered nurse, one (1) social worker, one (1) volunteer, and a volunteer program. A hospice facility is not a facility or part thereof which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics, or a hotel or similar institution.

*[(35)]***(54)** Hospital.

(A) An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic**,** and surgical facilities, all of which must be provided on its premises, under the supervision of a staff of one (1) or more physicians and with twenty-four (24)-hour-a-day nursing service by a registered nurse (RN) on duty or call.

(B) An institution not meeting all the requirements of *[(35)]***(54)**(A) *[of this rule]* **above**, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

(C) An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of Public Law 89-97).

(D) A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.

(E) A residential alcoholism, chemical dependency**,** or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction.

(F) In no event shall the term hospital include a skilled nursing facility or any institution or part thereof which is used primarily as a skilled nursing facility, nursing home, rest home**,** or facility for the aged.

*[(36)]***(55)** Hospital copayment. Set dollar amount a subscriber must pay for each hospital admission.

*[(37)]***(56)** Hospital room charges. The hospital's most common charge for semi-private accommodations, *[unless]* **or the most common charge for a private room if that is the only type of room available or if** a private room has been recommended by a physician and approved by the claims administrator or the plan administrator.

*[(38)]***(57)** Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered as any other illness.

*[(39)]***(58)** Incident. A definite and separate occurrence of a condition.

(59) Infertility. Any medical condition causing the inability or diminished ability to reproduce.

(60) Infertility services. Services including confinement, treatment, or other services related to the restoration of fertility or the promotion of conception.

*[(40)]***(61)** Injury. A condition that results independently of an illness and all other causes and is a result of an external force or accident.

*[(41)]***(62)** Inpatient. Confined to a registered bed. Patient in hospital, skilled nursing facility, hospice **facility,** or free-standing chemical dependency treatment center.

*[(42)]***(63)** Legend. Any drug that requires a prescription from either a physician or a practitioner, under either federal or applicable state law, in order to be dispensed.

(64) Life events. Events occurring in an individual's life to include: marriage, birth, adoption, or placement of children.

*[(43)]***(65)** Lifetime. The period of time *[you or your]* **a member or the member's** eligible dependents participate in the plan.

*[(44)]***(66)** Lifetime maximum. The maximum amount payable by a

medical plan during a covered member's life.

*[(45)]***(67)** Medical benefits coverage. Services that are received from providers recognized by the plan and are covered benefits under the plan.

*[(46)]***(68)** Medically necessary. Treatments, procedures, services**,** or supplies that the plan administrator determines, in the exercise of its discretion:

(A) Are expected to be of clear clinical benefit to the patient; and

(B) Are appropriate for the care and treatment of the injury or illness in question; and

(C) Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service**,** or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a *[health care]* provider has prescribed, ordered**,** or recommended a treatment, procedure, service**,** or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service**,** or supply must not be specifically excluded from coverage under this plan.

(69) Member. Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

(70) Morbid obesity. Body Mass Index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions approved by the plan administrator based on clinical review.

*[(47)]***(71)** Network provider. A physician, hospital, pharmacy, etc., that is contracted with the *[medical]* plan.

(72) Non-embedded deductible. The family deductible that must be met before claim payments begin, applicable when two (2) or more family members are covered in the HDHP.

*[(48)]***(73)** Non-formulary. A drug not contained on the *[health plan's or the]* pharmacy program's formulary list *[or preferred drug list]* **but may be covered under the terms and conditions of the plan**.

*[(49)]***(74)** Non-network provider or non-participating provider. Any physician, hospital, pharmacy, etc., that does not have a contract with the *[health]* plan *[or the pharmacy program]*.

*[(50)]***(75)** Nurse. A registered nurse (RN), licensed practical nurse (LPN)**,** or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule.

(76) Nursing home. An institution operated, pursuant to law, primarily for custodial care or for patients convalescing from illness or injury, under the supervision of a physician or registered nurse and having twenty-four (24)-hour nursing care. Also, an institution meeting the preceding criteria which is established for the treatment of sick and injured persons through spiritual means and is operated under the authority of organizations which are recognized under Medicare.

*[(51)]***(77)** Open enrollment period. A period designated by the plan during which subscribers may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year.

*[(52)]***(78)** Out-of-area. Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria.

*[(53)]***(79)** Out-of-network. Providers that do not participate in the member's health **or pharmacy** plan.

(80) Out-of-pocket maximum. The maximum amount the member must pay before the plan begins paying one hundred percent (100%) of covered charges for the remainder of the calendar year.

*[(54)]***(81)** Outpatient. Treatment either outside a hospital setting or at a hospital when room and board charges are not incurred.

(82) Outpatient observation stay. Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Most observation services are less than twenty-four (24) hours. Members may receive observation services in the emergency room, an observation unit, the intensive care unit, or a regular floor.

(83) Palliative services. Care provided by a team approach that improves the quality of life for patients and their families facing problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

*[(55)]***(84)** Partial hospitalization. A distinct and organized intensive ambulatory treatment service, less than twenty-four (24)-hour daily care specifically designed for the diagnosis and active treatment of a mental/nervous disorder when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.

(A) Partial hospitalization programs must provide diagnostic services; services of social workers; psychiatric nurses and staff trained to work with psychiatric patients; individual, group**,** and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions for therapeutic purposes.

(B) The facility providing the partial hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a physician.

*[(56)]***(85)** Participant. Any employee or dependent accepted for membership in the plan.

*[(57)]***(86)** Pharmacy benefit manager (PBM). Acts as a link between the parties involved in the delivery of prescription drugs to health plan members. The PBM designs, implements, **and** manages the overall drug benefit of the plan*[,]* and processes claims payments.

*[(58)]***(87)** Physically or mentally disabled. The inability of a person to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition.

*[(59)]***(88)** Physician/Doctor. A licensed practitioner of the healing arts, acting within the scope of his/her practice as licensed under section 334.021, RSMo.

*[(60)]***(89)** Plan. The program of health care benefits established by the trustees of the Missouri Consolidated Health Care Plan as authorized by state law.

*[(61)]***(90)** Plan administrator. The trustees of the Missouri Consolidated Health Care Plan. As such, the board is the sole fiduciary of the plan, has all discretionary authority to interpret its provisions and to control the operation and administration of the plan, and whose decisions are final and binding on all parties.

*[(62)]***(91)** Plan document. The statement of the terms and conditions of the plan as promulgated by the plan administrator in this chapter.

*[(63)]***(92)** Plan year. Same as *[benefit]* **calendar** year.

[(64) Point-of-service (POS). A plan which provides a wide range of comprehensive health care services, like an HMO, if in-network providers are utilized, and like a PPO plan, if non-network providers are utilized.]

*[(65)]***(93)** Pre-admission testing. X-rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission.

[(66) Pre-authorization. A cost control procedure that requires the service or medication to be approved in advance by the doctor and/or the plan. Without prior authorization, the plan may not pay for the test, drug, or service.]

*[(67)]***(94)** Pre-certification *[program]*. Also known as pre-admission certification, pre-admission review, and pre-certification. The process of obtaining certification or authorization from the plan for routine hospital admissions and surgical or diagnostic procedures (inpatient or outpatient).

*[(68)]***(95)** Pre-existing condition. A condition for which *[you have]* **a member has** incurred medical expenses or received treatment *[within the three (3) months]* prior to *[your]* **the** effective date of coverage.

*[(69)]***(96)** Preferred provider organization (PPO). An arrangement with providers where discounted rates are given to members of the plan who, in turn, are offered a financial incentive to use these providers.

*[(70)]***(97)** Prevailing fee. The fee charged by the majority of dentists.

*[(71)]***(98)** Primary care physician (PCP). A physician (usually an internist, family/general practitioner**,** or pediatrician) who has contracted with and been approved by *[an HMO or POS. The PCP is accountable for all medical services of members including referrals. The PCP supervises other provided care such as services of specialists and hospitalization]* **a medical plan**.

(99) Prior authorization. A cost control procedure that requires the service or medication to be approved in advance by the doctor and/or the plan. Without prior authorization, the plan may not pay for the test, drug, or service. Also know as pre-authorization or pre-notification.

*[(72)]***(100)** Prior plan. The terms and conditions of a plan in effect for the period preceding coverage in the *[MCHCP]* **plan**.

(101) Private duty nursing. Private duty nursing services, nursing care on a full-time basis in the member's home, or home health aides.

(102) Proof of eligibility. Documentation required by the plan to determine a dependent's qualification for health insurance coverage.

*[(73)]***(103)** Proof of insurance. Evidence in written form from an insurance company that provides verification of coverage for a given period of time.

(104) Proof of prior group coverage. If a member or his/her dependents enroll in the plan due to loss of coverage, the member must provide proof of prior group coverage. This includes a letter from the previous insurance carrier or former employer which states all the following:

(A) Date coverage was or will be terminated;

(B) Reason for coverage termination; and

(C) List of dependents covered.

*[(74)]***(105)** Prostheses. An artificial extension that replaces a missing part of the body. Prostheses are typically used to replace parts lost by injury (traumatic) or missing from birth (congenital) or to supplement defective parts.

(106) Protected health information. Any information, whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse. This information also relates to the past, present, or future physical or mental health or condition of the individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to the individual.

*[(75)]***(107)** Provider. Hospitals, physicians, chiropractors, medical agencies, or other specialists who provide medical care within the scope of his/her practice and are recognized under the provisions *[and administrative guidelines]* of the plan. Provider also includes a qualified practitioner of an organization which is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

(108) Provider directory. A listing of network providers within a health plan.

(109) Prudent layperson. An individual possessing an average knowledge of health and medicine.

(110) Qualified Medical Child Support Order (QMCSO). A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or an enrollee if the plan normally provides coverage for dependent children.

*[(76)]***(111)** Reconstructive surgery. A procedure performed to restore the anatomy and/or functions of the body that are lost or impaired due to an injury or illness.

*[(77)]***(112)** Refractions. A record of the patient's preference for the focusing of the eyes that can then be used to purchase eyeglasses. It is the portion of the eye exam that determines what prescription lens provides the patient with the best possible vision.

*[(78)]***(113)** Rehabilitation facility. A legally operating institution**,** or distinct part of an institution**,** that has a transfer agreement with one **(1)** or more hospitals and is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute hospital**,** and rehabilitative inpatient care and is duly licensed by the appropriate government agency to provide such services.

(A) It does not include institutions that provide only minimal care, custodial care, ambulatory or part-time care services, or an institution that primarily provides treatment of mental/nervous disorders, substance abuse**,** or tuberculosis, except if such facility is licensed,

certified**,** or approved as a rehabilitation facility for the treatment of mental/nervous conditions or substance abuse in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) or the Commission for the Accreditation of Rehabilitation Facilities.

(114) Retiree. A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-2.020(5)(B) and is currently receiving a monthly retirement benefit from one (1) of the retirement systems listed in such rule.

[(79) Review agency. A company responsible for administration of clinical management programs.]

*[(80)]***(115)** Second opinion program. A consultation and/or exam with a physician qualified to perform the procedure who is not affiliated with the attending physician/surgeon, for the purpose of evaluating the medical necessity and advisability of undergoing a surgical procedure or receiving a service.

[(81) Severe obesity. Body Mass Index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hyptertension, hypertension or other obesity related conditions which will be considered based on clinical review.]

(116) Skilled nursing care. Care which must be performed by, or under the supervision of, licensed personnel and meets criteria as established by the claims administrator.

*[(82)]***(117)** Skilled nursing facility (SNF). An institution which meets fully each of the following requirements:

(A) It is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, the following services for persons convalescing from sickness or injury: room, board**,** and twenty-four (24)-hour-a-day nursing service by one (1) or more professional nurses and nursing personnel as are needed to provide adequate medical care;

(B) It provides the services under the supervision of a proprietor or employee who is a physician or registered nurse; and it maintains adequate medical records and has available the services of a physician under an established agreement, if not supervised by a physician or registered nurse; and

(C) A skilled nursing facility shall be deemed to include institutions meeting the criteria in *[section (81) of]* this rule which are established for the treatment of sick and injured persons through spiritual means and are operated under the authority of organizations which are recognized under Medicare (Title I of Public Law 89-97).

*[(83)]***(118)** Sound natural teeth. Teeth and/or tissue that is viable, functional, and free of disease. A sound natural tooth has no decay, fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.

(119) Specialty care physician/specialist. A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

*[(84)]***(120)** Specialty *[drugs]* **medications**. High cost drugs that are primarily self-injectible but sometimes oral medications.

*[(85)]***(121)** State. Missouri.

(122) Step therapy. Designed to encourage use of therapeutically-equivalent, lower-cost alternatives before stepping up to more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

*[(86)]***(123)** Subrogation. The substitution of one **(1)** "party" for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan to stand in the place of the participant and recover the money directly from the other insurer.

*[(87)]***(124)** Subscriber. The employee or member who elects coverage under the plan.

(125) Subscriber only participation. Participation of a subscriber without participation of the subscriber's dependents, whether or not the subscriber has dependents.

(126) Surgery. Any operative or invasive diagnostic procedure performed in the treatment of an injury or illness by an instrument or cutting procedure through any natural body opening or incision.

(127) Surgery center (ambulatory). A hospital based, sponsored, or independently-owned facility that performs surgery.

*[(88)]***(128)** Survivor. A member who meets the requirements of **subsection** 22 CSR 10-2.020(5)(A).

*[(89)]***(129)** Unemancipated child(ren). A natural child(ren), a legally adopted child(ren) or a child(ren) placed for adoption, and a dependent disabled child(ren) over twenty-five (25) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:

(A) Stepchild(ren);

(B) Foster child(ren) for whom the employee is responsible for health care;

(C) Grandchild(ren) for whom the employee has legal custody and is responsible for providing health care; **and**

(D) Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator.

1. Except for a disabled child(ren) as described in section *[(58)]***(87)** of this rule, an unemancipated child(ren) is eligible from birth to the end of the month in which s/he is emancipated, as defined here, or attains age twenty-five (25) (see **paragraph** 22 CSR 10-2.020(3)(D)2. for continuing coverage on a handicapped child(ren) beyond age twenty-five (25)); and

(E) Stepchild(ren) who are not domiciled with the employee, provided the natural parent who is legally responsible for providing coverage is also covered as a dependent under the plan.

(130) Urgent care. Medically necessary services in order to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician office but not severe enough to require treatment in a hospital emergency department.

(131) Urgent care centers. Medical facilities that provide extended or twenty-four (24)-hour service to treat minor conditions at a lower cost than emergency room treatment.

*[(90)]***(132)** Usual, Customary, and Reasonable charge.

(A) Usual. The fee a physician most frequently charges the majority of his/her patients for the same or similar services.

(B) Customary. The range of fees charged in a geographic area by physicians of comparable skills and qualifications for the same performance of similar service.

(C) Reasonable. The flexibility to take into account any unusual clinical circumstances involved in performing a particular service.

(D) A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the doctors for ninety percent (90%) of the procedures reported.

*[(91)]***(133)** Utilization review. Evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities on a prospective, concurrent, or retrospective basis.

*[(92)]***(134)** Vested subscriber. A member who meets the requirements of **subsection** 22 CSR 10-2.020(5)(B).

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Amended: Filed Jan. 4, 2010.*

PUBLIC COST: This proposed amendment will cost the Missouri Consolidated Health Care Plan $387,006,125 annually in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities $115,616,203 annually in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 2

Rule Number and Name:	22 CSR 10-2.010 Definitions
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan	**$387,006,125**

III. WORKSHEET

Estimated cost is the annual cost of the MCHCP providing health care plans to all state employees and eligible retirees and dependents for calendar year 2010.

IV. ASSUMPTIONS

- **Total enrollment as of December 14, 2009 (data used the CY2010 projection);**
- **Calendar year 2010 membership would remain relatively stable;**
- **Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary.**
- **Actual costs will vary based upon actual utilization of services.**

FISCAL NOTE
PRIVATE COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 2

Rule Number and Title:	**22 CSR 10-2.010 Definitions**
Type of Rulemaking:	**Proposed Amendment**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
106,070 individuals enrolled in MCHCP plans for CY 2010	**Individuals enrolled in MCHCP plans for CY 2010**	**$ 115,616,203**

III. WORKSHEET

Estimated cost is the annual cost for all MCHCP subscribers' premium costs for calendar year 2010.

IV. ASSUMPTIONS

- Total enrollment as of December 14, 2009 (data used the CY2010 projection);
- Calendar year 2010 membership would remain relatively stable;
- Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary, and insured premiums developed by Mercy Health Plans;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.020 Subscriber Agreement and General Membership Provisions. The Missouri Consolidated Health Care Plan is amending the purpose and sections (1)–(3) and (5)–(8).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the Subscriber Agreement and General Membership Provisions of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule establishes the policy of the board of trustees in regard to the [employee's membership agreement and membership period for participation in] ***Subscriber Agreement and General Membership Provisions of*** *the Missouri Consolidated Health Care Plan.*

(1) The participant's initial application, any subsequently accepted modifications to such application, **the handbook,** and the plan document as adopted by the board along with duly executed amendments shall comprise the subscriber agreement between the participant and the Missouri Consolidated Health Care Plan (MCHCP). Any *[associated administrative guidelines]* **other written materials** interpret**ing** the subscriber agreement for the benefit of members and administrators *[but]* are not a part of the subscriber agreement.

(A) By applying for coverage under the MCHCP**,** a participant agrees that—

1. The employer may deduct the cost of the premium for the employee's plan from the employee's paychecks;

2. Individual and family deductibles, if appropriate, will be applied; and

3. Any individual eligible as an employee shall not be covered as a dependent unless the employee is on an approved leave of absence.

(2) The effective date of participation shall be determined, subject to the effective date provision in subsection (2)(C), as follows:

(A) Employee Participation.

1. If application by an employee is made on or before the date of eligibility, participation shall become effective on such date of eligibility;

2. If application by an employee is made within thirty-one (31) days after the date of eligibility, participation may become effective on the date of eligibility or the first day of the calendar month coinciding with or following the date *[of]* **the** application **is received**, except that participation shall be retroactive to the beginning of the month for employees rehired during the month following the month participation would have terminated; and

3. Not limiting or excluding any of the other provisions, if application is not made within thirty-one (31) days of the employee's date of eligibility, they may apply for coverage only if *[a life event occurs. Life events include: marriage, birth, adoption, death, divorce, legal separation, job loss or failure to elect continuation of coverage. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify the plan administrator of the life event;]* **one (1) of the following occurs:**

A. Occurrence of a life event which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify the plan administrator of the life event;

B. Loss of a spouse's employer-sponsored group coverage when the employee originally waived coverage through the plan. Application must be made within sixty (60) days of the time—

(I) The employee no longer qualifies for coverage under spouse's plan;

(II) The spouse's employment terminates or he/she is no longer eligible for coverage under employer's plan;

(III) The spouse's employer-sponsored medical, dental, and/or vision plan terminates;

(IV) All employer contributions toward the spouse's plan cease; or

(V) The employee's Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends; or

C. Loss of eligibility for Medicaid, in which case application for coverage through the plan must be made within sixty (60) days of loss;

(B) Dependent Coverage. Dependent participation cannot precede the subscriber's participation **except when coverage is added as a life event with birth of a child or adoption of a child at birth. The effective date for a child is the date of birth. The subscriber and/or dependent's effective date is the first day of the calendar month coinciding with or following the date of the application**. Application for participants must be made in accordance with the following provisions. Effective dates for all dependent coverage is wholly dependent upon *[paragraph (2)(B)1.]—*

1. Proof of eligibility documentation is required for all dependents. The plan reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by the plan administrator, coverage for the applicable dependent will either be terminated or will never take effect.

A. For the addition of dependents: Required documentation should accompany the application for coverage**, except when adding a newborn**. Failure to provide acceptable documentation with the application will result in the dependent not having coverage until such proof is received, subject to the *[deadline noted in part (2)(B)1.A.(I).]* **following:**

(I) If proof of eligibility is not received with the application, such proof will be requested by letter sent to the subscriber. Documentation shall be received no later than thirty (30) days from the date of the letter requesting such proof. Failure to provide the required documentation in a timely manner will result in the dependent being ineligible for coverage until the next open enrollment period unless a life event occurs*[.]***; and**

(II) Coverage is provided for a newborn of a member from the moment of birth. However, coverage will not continue past the first thirty-one (31) days unless required documentation is received;

2. Documentation is also required when a subscriber attempts to terminate a dependent's coverage in the case of divorce or death*[.]***;**

3. Acceptable forms of proof of eligibility are included in the following chart:

Circumstance	Documentation
Birth of dependent(s)	• Birth certificate; or • Hospital certificate
Addition of step-child(ren)	• Marriage license to biological parent of child(ren); and • Birth or Hospital certificate for child(ren) that names the subscriber's spouse as a parent
Addition of foster child(ren)	• Placement papers in subscriber's care
Adoption of dependent(s)	• Adoption papers; or • Placement papers
Legal guardianship of dependent(s)	• Court-documented guardianship papers (Power of Attorney is not acceptable)
Newborn of covered dependent	• *[Birth certificate for subscriber's child(ren); and* • *Birth certificate for subscriber's grandchild(ren)]* **Birth certificate for newborn listing covered dependent as parent with baby's name and birth date**
Marriage	• Marriage license; • Marriage certificate; or • Newspaper notice of the wedding
Divorce	• Final divorce decree; or • Notarized letter from spouse stating he/she is agreeable to termination of coverage pending divorce
Death	• Death certificate

4. For family coverage, once a subscriber is participating with respect to dependents, newly acquired dependents are automatically covered on their effective dates as long as the plan administrator is notified within thirty-one (31) days of the person becoming a dependent. First eligible dependents must be added within thirty-one (31) days of such qualifying event. The employee is required to notify the plan administrator on the appropriate form of the dependent's name, date of birth, eligibility date**,** and Social Security number, if available. Claims will not be processed until the required information is provided*[.]***;**

5. If an employee makes concurrent application for dependent participation on or before the date of eligibility or within thirty-one (31) days thereafter, participation for dependent will become effective on the date the employee's participation becomes effective;

6. When an employee participating in the plan first becomes eligible with respect to a dependent child(ren), coverage may become effective on the eligibility date or the first day of the month coinciding with or following the date of eligibility if application is made within thirty-one (31) days of the date of eligibility and provided any required contribution for the period is made; **and**

[7. Unless required under federal guidelines—

A. An emancipated dependent who regains his/her dependent status is immediately eligible for coverage if an application is submitted within thirty-one (31) days of regaining dependent status; and

B. An eligible dependent that is covered under a spouse's health plan who loses eligibility under the criteria stipulated for dependent status under the spouse's health plan is not eligible for coverage until the next open enrollment period. (Note: Subparagraphs (2)(B)7.A. and B. do not include dependents of retirees or long-term disability members covered under the plan); and]

*[8.]***7.** Survivors, retirees, vested subscribers**,** and long-term disability subscribers may only add dependents to their coverage when the dependent is first eligible for coverage**, except when a dependent's employer-sponsored coverage ends due to one (1) of the following:**

A. Termination of employment;

B. Retirement; and

C. Termination of group coverage by the employer.

Coverage must have been in place for twelve (12) months immediately prior to the loss, and coverage must be requested within sixty (60) days from the termination date of the previous coverage;

(C) Effective Date *[Proviso]* **Provision**. The effective date of coverage is the first of the month coinciding with or following *[your]* **the** eligibility date and the date the form is received by the plan. The effective date of coverage cannot be prior to the date of receipt of the enrollment form by the plan. The effective date for dependent coverage is wholly dependent upon the appropriate proof of eligibility documentation being timely received by the plan (see (2)(B)1.);

[(D) Application for dependent coverage may be made at other times of the year when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's: 1) employment is terminated or is no longer eligible for coverage under his/her employer's plan, or 2) employer-sponsored medical plan is terminated. With respect to dependent child(ren) coverage, application may also be made at other times of the year when the member receives a court order stating s/he is responsible for providing medical coverage for the dependent child(ren) or when the dependent loses Medicaid coverage. Dependents added under any of these exceptions must supply verification from the previous insurance carrier or the member's employer that they have lost coverage and the effective date of termination. Coverage must also be requested within sixty (60) days from the termination date of the previous coverage. Application must be made within sixty (60) days of the court order. (Note: This section does not include dependents of retirees, survivors, vested subscribers, or long-term disability subscribers covered under the plan);

(E) When an employee experiences applicable life events, eligibility will be administered according to Health Insurance Portability and Accountability Act (HIPAA) guidelines.]

(D) Application for dependent coverage may be made within sixty (60) days when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's—

1. Employer-sponsored medical, dental, or vision plan terminates or coverage by the employer is no longer offered;

2. The employer contributions toward the premiums cease;

3. COBRA coverage ceases; or

4. A dependent no longer qualifies due to age;

(E) Application may be made for dependent coverage within sixty (60) days of the event—

1. A Qualified Medical Child Support Order is received; or

2. A dependent no longer qualifies for Medicaid; or

(F) Application may be made for dependent coverage within thirty-one (31) days of an emancipated dependent regaining dependent status.

(3) Termination of participation shall occur on the last day of the calendar month coinciding with or following the happening of any of the following events, whichever shall occur first:

(A) Written **or phone** request by the employee;

(D) Termination of Eligibility for Participation.

1. With respect to employees, termination of participation shall occur upon termination of employment in a position covered by the MCHCP, except as specified in sections (4) and (5).

2. With respect to dependents, termination of participation shall occur upon ceasing to be a dependent as defined in this rule or upon

failure to provide the plan with acceptable proof of eligibility with the following exception: unemancipated mentally *[retarded]* and/or physically handicapped children will continue to be eligible beyond age twenty-five (25) during the continuance of a permanent disability provided documentation satisfactory to the plan administrator is furnished by a physician prior to the dependent's twenty-fifth birthday, and as requested at the discretion of the plan administrator.

3. Termination of employee's participation shall terminate the participation of dependents, except as specified in section (5).

(5) Continuation of Coverage.

(A) Dependents. Termination of an active employee's participation by reason of death shall not terminate participation with respect to the surviving spouse and/or dependent children if*[—]*

*[1. T]***t**he active employee was vested and eligible for a future retirement benefit*[; or]* **and**

[2. Your] eligible dependents meet one (1) of the following conditions:

*[A.]***1.** They have had coverage through MCHCP since the effective date of the last open enrollment period;

*[B.]***2.** They have had other health insurance for the six (6) months immediately prior to *[your]* **the employee's** death—proof of insurance is required; or

*[C.]***3.** They have had coverage through MCHCP since they were first eligible.

(C) Coverage at Termination. A former employee may participate in the plan if s/he terminates employment before retirement provided s/he is a vested employee. This means s/he will be eligible for a benefit from the Missouri State Employees' Retirement System, the Public School Retirement System, the retirement system of a participating public entity**,** or the *[Highway Retirement System]* **Missouri Department of Transportation and Highway Patrol Employees' Retirement System** when s/he reaches retirement age. Coverage may also be continued by a member of the general assembly, a state official holding a statewide elective office, or an employee employed by an elected state official or member of the general assembly whose employment is terminated because the state official or member of the general assembly ceases to hold elective office. The election to participate must be made within thirty-one (31) days from the last day of the month in which employment terminated. The member must pay the full cost of coverage. However, s/he will not later be eligible if s/he discontinues coverage at some future time.

(D) Leave of Absence. An employee on approved leave of absence may elect to retain eligibility to participate in the plan by paying the required contributions. The employing department must officially notify the plan administrator of the leave of absence and any extension of the leave of absence by submitting the required form. Any employee on an approved leave of absence who was a member of the Missouri Consolidated Health Care Plan when the approved leave began, but who subsequently terminated participation in the Missouri Consolidated Health Care Plan while on leave, may recommence his/her coverage in the plan at the same level (employee only*[,]* or employee and dependents) upon returning to employment directly from the leave*[, but they will be subject to preexisting limitations, when applicable. Preexisting limitations under this provision will not apply to health maintenance organization (HMO) or point-of-service (POS) members]*. However, eligibility is terminated for those members receiving a military leave of absence, as specified in subsection (3)(C). Coverage may be reinstated upon return from military leave *[without proof of insurability or preexisting conditions]*. However, the former member must complete an enrollment form. Coverage under this provision is effective on the first of the month coinciding with or following the employee's return to work. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date and timely requests reinstatement of coverage.

(F) Workers' Compensation. Any person who is receiving, or is entitled to receive, Workers' Compensation benefits as a result of an injury or accident sustained in employment and who was a member of the plan at the time of becoming disabled may continue his/her coverage in the plan at the same level of participation *[(employee only or employee and dependents)]* **(subscriber only or subscriber and dependents)** by paying the required contributions, if the disability occurred in the employment through which the employee qualifies for membership in the plan. Any person receiving, or entitled to receive, Workers' Compensation benefits who was a member of the plan at the time of becoming disabled as a result of an injury or accident sustained in employment through which the person qualified for membership in the plan, but who subsequently terminated participation in the plan, may recommence his/her coverage in the plan at the same level *[(employee only, or employee and dependents)]* **(subscriber only or subscriber and dependents)** upon returning to employment*[, without proving insurability]*.

(G) Reinstatement After Dismissal. If an employee is approved to return to work after being terminated as a result of legal or administrative action available as a recourse through his/her employer, s/he will be allowed to reinstate his/her medical benefit retroactively to the date of dismissal. If the employee is reinstated with back pay, s/he will be responsible for paying any contribution normally made for either his/her coverage or his/her covered dependents. *[No preexisting condition limitation will apply.]* If the employee is reinstated without back pay, s/he will be considered to have been on a leave of absence. Consequently, the employee will be responsible for making any required contribution toward the cost of his/her medical benefits. If the employee does not purchase coverage for the period between termination and reinstatement, s/he may regain the same level of coverage s/he had prior to termination. *[If the employee participates in a preferred provider organization (PPO) plan, the preexisting condition limitation will apply if coverage lapsed more than sixty-three (63) days. This does not apply if the employee participates in an HMO or POS.]*

(6) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) In accordance with the COBRA, eligible employees and their dependents may continue their medical coverage after the employee's termination date.

1. Employees terminating for reasons other than gross misconduct **or receiving a reduction in the number of hours of employment** may continue coverage for themselves and their covered dependents for eighteen (18) months at their own expense.

2. A surviving spouse and dependents, not normally eligible for continued coverage, may elect coverage for up to thirty-six (36) months at their own expense.

3. A divorced spouse may continue coverage at his/her own expense for up to thirty-six (36) months if the plan administrator is notified within sixty (60) days from the date coverage would terminate.

4. Dependent spouse and/or child(ren) may continue coverage up to thirty-six (36) months if the covered employee retires and the dependent spouse/child(ren) has not been covered by the plan for two (2) years.

5. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense if the plan administrator is notified within sixty (60) days of the loss of the dependent's eligibility.

6. Employees who are disabled at termination or become disabled during the first sixty (60) days of coverage may continue coverage for up to twenty-nine (29) months.

7. Premiums for continued coverage will be one hundred two percent (102%) of the health plan rate, one hundred fifty percent (150%) if disabled. Once coverage is terminated under the COBRA provision**,** it cannot be reinstated.

8. All operations under the COBRA provision will be applied in accordance with federal regulations.

(7) Missouri State Law COBRA Wrap-Around Provisions—Missouri law provides that if *[you lose your]* **a member loses** group health insurance coverage because of a divorce, legal separation**,** or the death of *[your]* **a** spouse**,** *[you]* **the member** may continue coverage until age sixty-five (65) if: a) *[You]* **The member** continue**s** and maintain**s** coverage under the thirty-six (36)-month provision of COBRA; and b) *[You are]* **The member is** at least fifty-five (55) years old when *[your]* COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions and will have to pay all of the application premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium. The above Cancellation of Continuation Coverage also applies to COBRA wrap-around continuation.

(8) *[Medicare—Participants eligible for Medicare who are not eligible for this plan as their primary plan, shall be eligible for benefits no less than those benefits for participants not eligible for Medicare. For such participants who elect to continue their coverage, benefits of this plan shall be coordinated with Medicare benefits on the then standard coordination of benefits basis to provide up to one hundred percent (100%) reimbursement for covered charges.*

(A) If a participant eligible for Medicare who is not eligible for this plan as the primary plan is not covered by Medicare, an estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim submitted basis so that if, for a given claim, Medicare reimbursement was for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims;

(B) If a participant eligible for Medicare Part D enrolls in a Medicare Part D plan in addition to coverage under this plan, such participant's coverage may be terminated under this plan in order for the plan to avoid liability for filing a false claim under the subsidy reimbursement portion of Medicare Part D; and

*(C)]*If any retired participants or long-term disability recipients, their eligible dependents**,** or surviving dependents eligible for coverage elect not to be continuously covered from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Amended: Filed Jan. 4, 2010.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.045 Plan Utilization Review Policy. The Missouri Consolidated Health Care Plan is amending the purpose and section (1).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule establishes the policy of the board of trustees in regard to the [utilization review] ***Plan Utilization Review Policy*** *of the Missouri Consolidated Health Care Plan Medical Plans.*

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program consists of four (4) parts, as described in the following:

(A) Precertification—The medical necessity of a non-emergency hospital admission, specified procedures as documented in the claims administrator's guidelines, and/or skilled nursing services provided on an inpatient basis must be prior authorized by the appropriate *[review agency]* **claims administrator**. For emergency hospital admissions, the *[review agency]* **claims administrator** must be notified within forty-eight (48) hours of the admission. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(B) Concurrent Review—The *[review agency]* **claims administrator** will continue to monitor the medical necessity of the admission and approve the continued stay in the hospital. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(C) Large Case Management—Members *[that]* **who** require long-term acute care may be offered the option of receiving the care, if appropriate, in a more cost-effective setting such as a skilled nursing facility or their own home. In some cases**,** this may require coverage for benefits that normally are not covered under the plan. These benefits may be provided through the approval of the claims administrator;

(E) Penalties—Members not complying with subsections (1)(A) and (B) of this rule may be subject to a financial penalty in connection with their covered benefits. *[(Note: The utilization review program will be operated in accordance with the administrative guidelines.)]*

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Amended: Filed Jan. 4, 2010.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.050 *[PPO and Co-Pay]* ***Copay Plan*** **Benefit Provisions and Covered Charges**. The Missouri Consolidated Health Care Plan is amending the purpose and sections (1)–(4).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the Copay Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule establishes the [benefit provisions and covered charges in] ***policy of the board of trustees in regard to the Copay Plan Benefit Provisions and Covered Charges of*** *the Missouri Consolidated Health Care Plan [PPO and/or Co-Pay Plan].*

(1) **Non-network** *[D]***d**eductible amount—per individual for the *[Preferred Provider Organization (PPO)]* **Copay** *[p]***P**lan each calendar year, *[five hundred dollars ($500)]* **six hundred dollars ($600)**, family limit each calendar year, one thousand **two hundred** dollars *[($1,000)]* **($1,200)**.

(2) Coinsurance—non-network coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once out-of-pocket maximum is reached.

(A) Coinsurance is seventy percent (70%) after deductible is met when utilizing non-network providers.

*[(A)]***(B)** The deductible is waived and claims are paid at eighty percent (80%) for the following services: home health care, infusion, durable medical equipment (DME), and audiologists.

*[(B)]***(C)** Claims may also be paid at eighty percent (80%) if *[you]* **the subscriber** requires covered services that are not available through a network provider *[in your area]* **within fifty (50) miles of his/her home**. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

*[(C)]***(D)** Non-network claims—**are paid at** seventy percent (70%) *[of the first four thousand dollars ($4,000)]* **until two thousand four hundred dollars ($2,400) has been met** for an individual, *[or of the first eight thousand dollars ($8,000)]* **four thousand eight hundred dollars ($4,800) has been met** for a family, of covered charges in the calendar year which are subject to coinsurance. **Claims are paid at** *[O]***o**ne hundred percent (100%) of any excess covered charges in the calendar year. *[But see the provision applicable to second opinion, substance abuse, and mental and nervous conditions, chiropractic care, and PPOs.]*

(3) *[Co-payments]* **Copayments**—set charges for the following types of claims so long as network providers are utilized. *[Co-payments are no longer charged for the remainder of the calendar year once out-of-pocket maximum is reached with the exceptions noted under (3)(G).]*

(A) Office visit—**primary care:** twenty-five dollars ($25)**; specialist: thirty-five dollars ($35)**.

(C) Inpatient hospitalizations—three hundred dollars ($300) per admission**; one thousand two hundred dollars ($1,200) annual maximum inpatient copayment**.

(D) Maternity—**primary care:** twenty-five dollars ($25) for initial visit**; specialist: thirty-five dollars ($35)**.

(F) Outpatient surgery—*[seventy-five dollars ($75)]* **one hundred dollars ($100)**.

[(G) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: office visits, emergency room visits, hospital admissions, outpatient surgery, claims for services paid at one hundred percent (100%), charges above the Usual, Customary, and Reasonable (UCR) limit, percentage amount coinsurance is reduced as a result of non-compliance with pre-certification, coinsurance amounts related to infertility benefits, and charges above the maximum allowable amount for transplants performed by a non-network provider.]

(G) Emergency room—one hundred dollars ($100) network and non-network.

(H) Urgent care—thirty-five dollars ($35) network and non-network.

(4) Out-of-pocket **non-network** maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year. *[Certain co-payments do not apply to the out-of-pocket maximum as noted under (3)(G).]*

[(A) Network out-of-pocket maximum for individual—two thousand dollars ($2,000);

(B) Network out-of-pocket maximum for family—four thousand dollars ($4,000);]

*[(C)]***(A)** Non-network out-of-pocket maximum for individual—*[four thousand dollars ($4,000);]* **two thousand four hundred dollars ($2,400); and**

*[(D)]***(B)** Non-network out-of-pocket maximum for family—*[eight thousand dollars ($8,000);]* **four thousand eight hundred dollars ($4,800).**

(C) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include: copayments; claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Amended: Filed Jan. 4, 2010.*

PUBLIC COST: This proposed amendment will cost the Missouri Consolidated Health Care Plan $293,606,952 annually in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities $77,530,644 annually in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 2

Rule Number and Name:	22 CSR 10-2.050 Copay Plan Benefit Provisions and Covered Charges
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan	**$ 293,606,952 annual**

III. WORKSHEET

Estimated cost is the annual cost of the MCHCP providing the Copay Plan to all state employees and eligible retirees and dependents who enrolled for coverage under this plan for calendar year 2010.

IV. ASSUMPTIONS

- **Total enrollment under the Copay Plan as of December 14, 2009 (data used the CY2010 projection);**
- **Calendar year 2010 membership in the Copay Plan would remain relatively stable;**
- **Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary;**
- **Actual costs will vary based upon actual utilization of services.**

FISCAL NOTE
PRIVATE COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 2

Rule Number and Title:	**22 CSR 10-2.050 Copay Plan Benefit Provisions and Covered Charges**
Type of Rulemaking:	**Proposed Amendment**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
89,527 individuals enrolled in the MCHCP Copay Plan for CY 2010	**Individuals enrolled in the MCHCP Copay Plan for CY 2010**	**$77,530,644**

III. WORKSHEET

Estimated cost is the annual cost for all MCHCP subscribers' premium costs for coverage under the Copay Plan for calendar year 2010. In addition, members will pay the following copayments based upon their individual utilization of covered benefits under the Copay Plan:

- $25 copayment for a primary care physician office visit
- $35 copayment for a specialist physician office visit or urgent care visit
- $100 copayment for emergency room visit
- $300 copayment for an inpatient hospital admission
- $100 copayment for outpatient surgery

IV. ASSUMPTIONS

- Total enrollment in the Copay Plan as of December 14, 2009 (data used for the CY2010 projection);
- Calendar year 2010 membership in the Copay Plan would remain relatively stable;
- Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED RULE

22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 300 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

(1) Deductible amount—Network: per individual each calendar year, three hundred dollars ($300); family limit each calendar year, six hundred dollars ($600). Non-network: per individual each calendar year, six hundred dollars ($600); family limit each calendar year, one thousand two hundred dollars ($1,200).

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once out-of-pocket maximum is reached.

(A) Network claims—are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims may also be paid at ninety percent (90%) if the subscriber requires covered services that are not available through a network provider within fifty (50) miles of his/her home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network out-of-pocket maximum for individual—one thousand two hundred dollars ($1,200).

(B) Network out-of-pocket maximum for family—two thousand four hundred dollars ($2,400).

(C) Non-network out-of-pocket maximum for individual—two thousand four hundred dollars ($2,400).

(D) Non-network out-of-pocket maximum for family—four thousand eight hundred dollars ($4,800).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include: claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(4) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Original rule filed Jan. 4, 2010.

PUBLIC COST: This proposed rule will cost the Missouri Consolidated Health Care Plan $24,755,921 annually in the aggregate.

PRIVATE COST: This proposed rule will cost private entities $10,812,931 annually in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 2

Rule Number and Name:	22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan	**$ 24,755,921**

III. WORKSHEET

Estimated cost is the annual cost of the MCHCP providing the PPO 300 Plan to all state employees and eligible retirees and dependents who enrolled for coverage under this plan for calendar year 2010.

IV. ASSUMPTIONS

- **Total enrollment under the PPO 300 Plan as of December 14, 2009 (data used the CY2010 projection);**
- **Calendar year 2010 membership in the PPO 300 Plan would remain relatively stable;**
- **Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary;**
- **Actual costs will vary based upon actual utilization of services.**

FISCAL NOTE
PRIVATE COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 2

Rule Number and Title:	**22 CSR 10-2.051 PPO 300 Benefit Provisions and Covered Charges**
Type of Rulemaking:	**Proposed Rule**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
8,551 individuals enrolled in the MCHCP PPO 300 Plan for CY 2010	**Individuals enrolled in the MCHCP PPO 300 Plan for CY 2010**	**$10,812,931**

III. WORKSHEET

Estimated cost is the annual cost for all MCHCP subscribers' premium costs for coverage under the PPO 300 Plan for calendar year 2010. In addition, members will pay the following deductible and coinsurance amounts based upon their individual utilization of covered benefits under the PPO 300 Plan:

- $300 individual network deductible
- $600 family network deductible
- $600 individual non-network deductible
- $1,200 family non-network deductible
- 10 percent network coinsurance after deductible
- 30 percent non-network coinsurance after deductible
- $1,200 individual network out-of-pocket maximum
- $2,400 family network out-of-pocket maximum
- $2,400 individual non-network out-of-pocket maximum
- $4,800 family non-network out-of-pocket maximum

IV. ASSUMPTIONS

- Total enrollment in the PPO 300 Plan as of December 14, 2009 (data used for the CY2010 projection);
- Calendar year 2010 membership in the PPO 300 Plan would remain relatively stable;

- Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1)–(3) and (5).

PURPOSE: This amendment includes changes to the High Deductible Health Plan Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

(1) Deductible amount—*[In]* Network: per individual *[for the High Deductible Health Plan (HDHP)]* each calendar year, one thousand two hundred dollars ($1,200)*[,]***;** family limit each calendar year, two thousand four hundred dollars ($2,400). Non-network: per individual *[for the High Deductible Health Plan (HDHP)]* each calendar year, two thousand four hundred dollars ($2,400)*[,]***;** family limit each calendar year, four thousand eight hundred dollars ($4,800).

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once out-of-pocket maximum is reached. *[Coinsurance is twenty percent (20%) after deductible is met when utilizing network providers. Coinsurance is forty percent (40%) after deductible is met when utilizing non-network providers. Claims may also be paid at eighty percent (80%) if you require covered services that are not available through a network provider in your area. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.]*

(A) Network claims—are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims may also be paid at eighty percent (80%) if the subscriber requires covered services that are not available through network provider within fifty (50) miles of his/her home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network out-of-pocket maximum for individual—two thousand four hundred dollars ($2,400)*[;]***.**

(B) Network out-of-pocket maximum for family—four thousand eight hundred dollars ($4,800)*[;]***.**

(C) Non-network out-of-pocket maximum for individual—four thousand eight hundred dollars ($4,800)*[;]***.**

(D) Non-network out-of-pocket maximum for family—nine thousand six hundred dollars ($9,600)*[;]***.**

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(5) *[Prescription costs are applied to the medical plan deductible.]* **Pharmacy benefits are subject to the applicable medical plan deductible and coinsurance.**

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Amended: Filed Jan. 4, 2010.

PUBLIC COST: This proposed amendment will cost the Missouri Consolidated Health Care Plan eight hundred fourteen thousand two hundred eighty-four dollars ($814,284) annually in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities two hundred forty-three thousand four hundred eight dollars ($243,408) annually in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 2

Rule Number and Name:	22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan	**$ 814,284**

III. WORKSHEET

Estimated cost is the annual cost of the MCHCP providing the High Deductible Health Plan (HDHP) to all state employees and eligible retirees and dependents who enrolled for coverage under this plan for calendar year 2010.

IV. ASSUMPTIONS

- **Total enrollment under the HDHP as of December 14, 2009 (data used the CY2010 projection);**
- **Calendar year 2010 membership in the HDHP would remain relatively stable;**
- **Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary;**
- **Actual costs will vary based upon actual utilization of services.**

FISCAL NOTE
PRIVATE COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 2

Rule Number and Title:	**22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges**
Type of Rulemaking:	**Proposed Amendment**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
190 individuals enrolled in the MCHCP HDHP for CY 2010	**Individuals enrolled in the MCHCP HDHP for CY 2010**	**$243,408**

III. WORKSHEET

Estimated cost is the annual cost for all MCHCP subscribers' premium costs for coverage under the High Deductible Health Plan (HDHP) for calendar year 2010. In addition, members will pay the following deductible and coinsurance amounts based upon their individual utilization of covered benefits under the HDHP:

- $1,200 individual network deductible
- $2,400 family network deductible
- $2,400 individual non-network deductible
- $4,800 family non-network deductible
- 20 percent network coinsurance after deductible
- 40 percent non-network coinsurance after deductible
- $2,400 individual network out-of-pocket maximum
- $4,800 family network out-of-pocket maximum
- $4,800 individual non-network out-of-pocket maximum
- $9,600 family non-network out-of-pocket maximum

IV. ASSUMPTIONS

- Total enrollment in the HDHP as of December 14, 2009 (data used for the CY2010 projection);
- Calendar year 2010 membership in the HDHP would remain relatively stable;

- Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED RULE

22 CSR 10-2.054 Medicare Supplement Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Medicare Supplement Plan Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

(1) Eligibility—Subscribers and dependents covered in this plan must be enrolled in Medicare, and the subscribers must receive a monthly retirement benefit from either the Missouri State Employees' Retirement System (MOSERS) or from the Public School Retirement System (PSRS), based on years of service. A subscriber may enroll in this plan when first eligible for Medicare.

(2) Available services—The Medicare Supplement Plan covers coinsurance amounts on Medicare Parts A and B eligible benefits after the Medicare deductibles are met.

(A) Inpatient hospital care—covers Medicare Part A coinsurance plus coverage for three hundred sixty-five (365) additional days after Medicare coverage ends;

(B) Medical costs—covers Medicare Part B coinsurance;

(C) Blood—covers the first three (3) pints of blood each year; and

(D) Prescription drug coverage.

(3) Limitations and exclusions—

(A) Charges above Medicare allowed amounts are the member's responsibility; and

(B) Limitations and exclusions follow Medicare guidelines.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Original rule filed Jan. 4, 2010.

PUBLIC COST: This proposed rule will cost the Missouri Consolidated Health Care Plan fifty-five thousand one hundred four dollars ($55,104) annually in the aggregate.

PRIVATE COST: This proposed rule will cost private entities thirty-three thousand one hundred sixty-eight dollars ($33,168) annually in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 2

Rule Number and Name:	22 CSR 10-2.054 Medicare Supplement Plan Benefit Provisions and Covered Charges
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan	**$ 55,104**

III. WORKSHEET

Estimated cost is the annual cost of the MCHCP providing the Medicare Supplement Plan to all state eligible retirees and dependents who enrolled for coverage under this plan for calendar year 2010.

IV. ASSUMPTIONS

- **Total enrollment under the Medicare Supplement Plan as of December 14, 2009 (data used the CY2010 projection);**
- **Calendar year 2010 membership in the Medicare Supplement Plan would remain relatively stable;**
- **Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary;**
- **Actual costs will vary based upon actual utilization of services.**

FISCAL NOTE
PRIVATE COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 2

Rule Number and Title:	**22 CSR 10-2.054 Medicare Supplement Plan Benefit Provisions and Covered Charges**
Type of Rulemaking:	**Proposed Rule**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
21 individuals enrolled in the MCHCP Medicare Supplement Plan for CY 2010	**Individuals enrolled in the MCHCP Medicare Supplement Plan for CY 2010**	**$ 33,168**

III. WORKSHEET

Estimated cost is the annual cost for all MCHCP subscribers' premium costs for coverage under the Medicare Supplement Plan for calendar year 2010. In addition, members will pay the following deductibles and services not covered by Medicare:

- Long-term care
- Hearing aids
- Skilled nursing facility coinsurance for days 21-100
- Part A hospital deductible
- Part B deductible

IV. ASSUMPTIONS

- Total enrollment in the Medicare Supplement Plan as of December 14, 2009 (data used for the CY2010 projection);
- Calendar year 2010 membership in the Medicare Supplement Plan would remain relatively stable;
- Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending the purpose and sections (1) and (2).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the Medical Plan Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule establishes the policy of the board of trustees in regard to the [benefit provisions and covered charges] ***Medical Plan Benefit Provisions and Covered Charges*** *for participation in the Missouri Consolidated Health Care Plan [Co-Pay Plan].*

(1) Benefit Provisions **Applicable to the HMO, Copay, PPO 300, and HDHP Plans**.

(A) Subject to the plan provisions and limitations and the written application of the employee, the benefits are payable for covered charges incurred by a participant while covered under the *[co-pay or preferred provider organization (PPO)]* plan**s**, provided the deductible requirement, if any, is met.

(D) The total amount of benefits payable for all covered charges incurred *[out-of]***non**-network during an individual's lifetime shall not exceed the lifetime maximum.

[(E) If both husband and wife are participating separately as employees under this plan, the family deductible and benefit features shall nevertheless apply to the benefit of the family unit.]

(2) Covered Charges **Applicable to the HMO, Copay, PPO 300, and HDHP Plans**.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Amended: Filed Jan. 4, 2010.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.060 PPO *300 Plan*, HDHP, *[and Co-Pay] Copay, and HMO* Plan Limitations. The Missouri Consolidated Health Care Plan is amending the purpose and sections (2) and (5); adding new sections (8), (17), (40), (44), and (48)–(51); renumbering and amending sections (8)–(37), (39)–(41), and (43)–(52); and removing sections (38) and (42).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the PPO 300 Plan, HDHP, Copay Plan, and HMO Limitations for members of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule establishes the [limitations and exclusions of the Missouri Consolidated Health Care Plan PPO, HDHP, and/or Co-Pay Plan] ***policy of the board of trustees in regard to the PPO 300 Plan, HDHP, Copay, and HMO Plan Limitations of the Missouri Consolidated Health Care Plan****.*

(2) If applicable, all hospitalizations, outpatient treatment for chemical dependency**,** or mental and nervous disorder that *[are not precertified]* **do not receive prior authorization** as described in 22 CSR 10-2.045, reimbursement will be reduced by ten percent (10%) of reasonable and customary charges.

(5) Alternative therapies—including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, biofeedback, and other forms of alternative therapy **with the exception of aquatic therapy performed by a physical therapist**.

(8) Breast augmentation mammoplasty—not covered unless associated with breast surgery following a medically necessary mastectomy incurred secondary to active disease.

*[(8)]***(9)** Care received without charge.

*[(9)]***(10)** Comfort and convenience items.

*[(10)]***(11)** Cosmetic, plastic, reconstructive**,** or restorative surgery—unless medically necessary to repair a functional disorder caused by disease, injury**,** or congenital defect or abnormality (for a participant under the age of nineteen (19)) or to restore symmetry following a mastectomy.

*[(11)]***(12)** Custodial or domiciliary care—includes services and supplies that assist members in the activities of daily living like walking, getting in and out of bed, bathing, dressing, feeding**,** and using the toilet; preparation of special diets and supervision of medication that is usually self-administered.

*[(12)]***(13)** Dental—treatment must be initiated within sixty (60) days of accident. Limited to treatment of accidental injury to sound natural teeth. Oral surgery is covered only when medically necessary as a direct result from injury, tumors**,** or cysts. Dental care, including oral surgery, as a result of poor dental hygiene is not covered. Extractions of bony or partial bony impactions are excluded.

*[(13)]***(14)** Durable medical equipment and disposable supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings**,** and support hose. Over-the-counter medications and supplies. Prescription compression stockings are limited to two (2) pairs of four (4) individual stockings per plan year.

*[(14)]***(15)** Educational or psychological testing—not covered unless part of a treatment program for covered services.

*[(15)]***(16)** Examinations requested by a third party.

(17) Excessive charges—any otherwise eligible expenses that exceed the maximum allowance or benefit limit.

*[(16)]***(18)** Exercise equipment.

*[(17)]***(19)** Experimental services or investigational services—experimental or investigational services, procedures, supplies**,** or drugs as determined by the claims administrator are not covered, except clinical trials for cancer treatment as specified by law.

*[(18)]***(20)** Eye glasses and contact lenses—charges incurred in connection with the fitting of eye glasses or contact lenses except for initial placement immediately following cataract surgery.

*[(19)]***(21)** Eye services—health services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK**,** and other refractive eye surgery.

*[(20)]***(22)** Services obtained at a government facility—not covered if care is provided without charge.

*[(21)]***(23)** Hair analysis, wigs**,** and hair transplants—services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also, hairstyling wigs, hairpieces**,** and hair prostheses, including those ordered by a participating provider**,** are not covered. Such items and services are not covered except for members ages eighteen (18) and under with alopecia as specified by law. Subject to two hundred dollar ($200) annual maximum and three thousand two hundred dollar ($3,200) lifetime maximum.

*[(22)]***(24)** Health and athletic club membership—including costs of enrollment.

*[(23)]***(25)** Immunizations requested by third party or for travel.

*[(24)]***(26)** Infertility—*[not covered.]* **Infertility treatments are limited to in-vivo (intrauterine, intracervical, intravaginal fertilization).** Those health services and associated expenses for the treatment of infertility **are not covered,** including reversal of voluntary sterilization, intracytoplasmic sperm injection (ICSI), *in vitro* fertilization, gamete intrafallopian transfer (GIFT)**,** and zygote intrafallopian transfer (ZIFT) procedures; embryo transport; donor sperm and related cost for collection; no cryopreservation of sperm or eggs; and non-medically necessary amniocentesis.

*[(25)]***(27)** Level of care, if greater than is needed for the treatment of the illness or injury.

*[(26)]***(28)** Medical care and supplies—not to the extent that they are payable under—

(A) A plan or program operated by a national government or one **(1)** of its agencies; or

(B) Any state's cash sickness or similar law including any group insurance policy approved under such law.

*[(27)]***(29)** Medical service performed by a family member—including a person who ordinarily resides in *[your]* **the subscriber's** household or is related to the participant, such as a spouse, parent, child, sibling**,** or brother/sister-in-law.

*[(28)]***(30)** Military service connected injury or illness.

*[(29)]***(31)** Non-network providers—subject to deductible and non-network coinsurance.

*[(30)]***(32)** Not medically necessary services—with the exception of preventive services.

*[(31)]***(33)** Obesity—medical and surgical intervention is not covered, unless the member meets the definition of severe **morbid** obesity as defined in 22 CSR 10-2.010 *[and such severe obesity has persisted for at least five (5) years]* **and satisfies all requirements described in the plan**. Bariatric surgery will only be covered when prior authorization is received from the medical plan. *[Please see the current State Member Handbook for further limitations regarding bariatric surgery.]*

(A) Bariatric surgery additional qualifying criteria—

1. Presence of severe morbid obesity that has persisted for at least five (5) years defined as body mass index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions approved by the plan based on clinical review;

2. Member must be eighteen (18) years of age or older;

3. Documented evidence of at least two (2) failed attempts at weight loss each with a minimum duration of at least six (6) months with the member achieving at least a ten percent (10%) weight loss and meeting the following additional criteria: one (1) attempt must be in a physician-supervised weight loss program and fully documented in the physician's record; the program must use a multidisciplinary approach including dietician consultation, low-calorie diet, increased physical activity, and behavioral modification; nationally recognized program such as Jenny Craig or Weight Watchers (This does not include self-directed low-calorie diets such as the Atkins Diet or South Beach Diet.); and the most recent attempt must have been within the twelve (12)-month period prior to the requested surgery;

4. Documented evidence the member is on a nutrition and exercise program immediately prior to the surgery request;

5. Evidence the member and the attending physician have a life-long plan for compliance with lifestyle modification requirements;

6. Documentation the member has completed a psychological evaluation and, if appropriate, behavior modification and should be free of major psychiatric diagnosis or a current behavior which would significantly reduce long-term effectiveness of the proposed treatment; and

7. Procedure must be performed at a Centers of Excellence (COE) facility for Bariatric Surgery as determined by the Centers for Medicare and Medicaid Services.

(B) Network services are limited to one (1) operative procedure for the treatment of obesity per lifetime. Non-network obesity services are not covered.

(C) Revisions and corrections of bariatric procedures are covered only when the revision or correction is used to treat life-threatening complications (e.g., wound infection, abscess, dehiscence, gastric leaking, and embolism). Coverage is limited to the following bariatric procedures: Roux-en-Y Gastric Bypass—open and laparoscopic (RYGBP), Laparoscopic Adjustable Gastric Banding (LAGB), and Open and Laparoscopic Biliopancreatic Diversion with Duodenal Switch (BPD/DS).

*[(32)]***(34)** Orthognathic surgery.

*[(33)]***(35)** Orthoptics.

*[(34)]***(36)** Other charges—no coverage for charges that would not be incurred if *[you were]* **the subscriber was** not covered. Charges for which *[you]* **the subscriber** or *[your]* **his/her** dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted. Charges made in *[your]* **the subscriber's** name but which are actually due to the injury or illness of a different person not covered by the plan. **Miscellaneous service charges—telephone consultations, charges for failure to keep**

scheduled appointment (unless the scheduled appointment was for a mental health service), or any late payment charge.

*[(35)]***(37)** Over-the-counter medications—except for insulin through the pharmacy benefit.

*[(36)]***(38)** Over-the-counter supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings**,** and support hose.

*[(37)]***(39)** Physical fitness.

(40) Physical, speech, and occupational therapy—health services and associated expenses for development delay. Treatment for disorders relating to delays in learning, motor skills, and communications.

[(38) Pre-existing conditions—not covered for charges associated with pre-existing conditions.]

*[(39)]***(41)** Private duty nursing.

*[(40)]***(42)** Prosthetic repair or replacement—not covered unless due to normal wear and tear, if there is a change in medical condition, if growth related**,** or medically necessary.

*[(41)]***(43)** Services not specifically included as benefits.

(44) Services rendered after termination of coverage—those services otherwise covered under the agreement, but rendered after the date coverage under the agreement terminates, including services for medical conditions arising prior to the date individual coverage under the agreement terminates.

[(42) Smoking cessation—patches and gum are not covered. There is a limited benefit available under the pharmacy benefit.]

*[(43)]***(45)** Stimulators (for bone growth)—not covered unless authorized by claims administrator.

*[(44)]***(46)** Surrogacy—pregnancy coverage is limited to plan member.

*[(45)]***(47)** Temporo-Mandibular Joint Syndrome (TMJ).

(48) Third-party examinations.

(49) Tobacco cessation—patches and gum are not covered. There is a limited benefit available under the pharmacy benefit.

(50) Transplants—double listing—payment only for one (1) evaluation up to time of actual transplant.

(51) Transplants—travel expense—requires authorization from medical plan. Limited to ten thousand dollar ($10,000) maximum per transplant when accessing network services.

*[(46)]***(52)** Transsexual surgery—health services and associated expenses in the transformation operations regardless of any diagnosis or gender role disorientation or psychosexual orientation or any treatment or studies related to sex transformation. Also excludes hormonal support for sex transformation.

*[(47)]***(53)** Travel expenses—not covered unless authorized by claims administrator.

*[(48)]***(54)** Trimming of nails, corns**,** or calluses—not covered except for persons being treated for diabetes, peripheral vascular disease**,** or blindness.

*[(49)]***(55)** Usual, Customary**,** and Reasonable (UCR)—charges exceeding UCR are not covered, as applicable to the non-network benefit.

*[(50)]***(56)** Vitamins and nutrients—limited to prenatal agents for pregnancy, therapeutic agents for specific deficiencies and conditions**,** and hematopoietic agents through the pharmacy benefit.

*[(51)]***(57)** War or insurrection—liability to provide services limited in the event of a major disaster, epidemic, riot**,** or other circumstances beyond the control of the plan.

*[(52)]***(58)** Workers' compensation—*[charges for services and treatment of an injury incurred during the course of employment and covered by Workers' Compensation, occupational disease law or similar laws, including all charges to be covered by any associated settlement agreement]* **charges for services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other legislation of similar program**.

AUTHORITY: section 103.059, RSMo 2000 ***and section 103.080.3, RSMo Supp. 2009****. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Amended: Filed Jan. 4, 2010.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.064 HMO *[and POS]* **Summary of Medical Benefits**. The Missouri Consolidated Health Care Plan is amending the purpose and sections (1) and (2).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to HMO Summary of Medical Benefits for members of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule establishes the [benefit provisions and covered charges in] ***policy of the board of trustees in regard to the***

***HMO Summary of Medical Benefits of** the Missouri Consolidated Health Care Plan [HMO and POS Plans].*

(1) Co*[-]*payments—set charges for the following types of claims so long as network providers are utilized.

(A) Office visit—**primary care:** twenty-five dollars ($25)**; specialist: thirty-five dollars ($35)**.

(C) Inpatient hospitalizations—three hundred dollars ($300) per admission**; one thousand two hundred dollars ($1,200) annual maximum inpatient copayment**.

(D) Maternity—**primary care:** twenty-five dollars ($25) for initial visit**; specialist: thirty-five dollars ($35)**.

(F) Outpatient surgery—*[seventy-five dollars ($75)]* **one hundred dollars ($100)**.

(G) Emergency room—one hundred dollars ($100).

(H) Urgent care—thirty-five dollars ($35).

(2) Out-of-pocket maximum—Limited to no more than fifty percent (50%) of the cost of providing a single service. Co*[-]*payments are limited to no more than twenty percent (20%) of the cost of providing basic health care services for the total benefit period and may not exceed two hundred percent (200%) of the total annual premium. **The total annual premium is any amount paid by, or on behalf of, the member.**

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Amended: Filed Jan. 4, 2010.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities $7,570,788 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 2

Rule Number and Title:	**22 CSR 10-2.064 HMO Summary of Medical Benefits**
Type of Rulemaking:	**Proposed Amendment**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
3,870 individuals enrolled in the MCHCP HMO Plan for CY 2010	**Individuals enrolled in the MCHCP HMO Plan for CY 2010**	**$ 7,570,788**

III. WORKSHEET

Estimated cost is the annual cost for all MCHCP subscribers' premium costs for all MCHCP subscribers enrolled in the MCHCP HMO Plan available in the Southwest and South Central Regions of Missouri for calendar year 2010. In addition, members will pay the following copayments based upon their individual utilization of covered benefits under the MCHCP HMO Plan:

- $25 copayment for a primary care physician office visit
- $35 copayment for a specialist physician office visit or urgent care visit
- $100 copayment for emergency room visit
- $300 copayment for an inpatient hospital admission
- $100 copayment for outpatient surgery

IV. ASSUMPTIONS

- Total enrollment in the HMO Plan as of December 14, 2009 (data used for the CY2010 projection);
- Calendar year 2010 membership in the HMO Plan would remain relatively stable;
- Calendar year 2010 rates based on fully-insured premium as calculated by Mercy Health Plans;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED RESCISSION

22 CSR 10-2.067 HMO and POS Limitations. This rule established the limitations and exclusions of the Missouri Consolidated Health Care Plan HMO and/or POS Plan.

PURPOSE: This rule is being rescinded because the limitations have been incorporated into another rule.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Rescinded: Filed Jan. 4, 2010.*

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED RULE

22 CSR 10-2.090 Pharmacy Benefit Summary

PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions of the pharmacy benefit for the HMO, Copay, PPO 300, and Medicare Supplement Plans of the Missouri Consolidated Health Care Plan.

(1) The pharmacy benefit provides coverage for prescription drugs, as described in the following:

(A) Medications.

1. Network:

A. Generic: Eight dollar ($8) copayment for up to a thirty (30)-day supply for generic drug on the formulary;

B. Formulary brand: Thirty-five dollar ($35) copayment for up to a thirty (30)-day supply for brand drug on the formulary;

C. Non-formulary: Fifty-five dollar ($55) copayment for up to a thirty (30)-day supply for non-formulary drug;

D. Prescriptions filled with a formulary brand drug when there is a Food and Drug Administration (FDA)-approved generic will be subject to the generic copayment amount in addition to paying the difference between the cost of the generic and the formulary brand drug;

E. Mail order program—

(I) Prescriptions may be filled through the mail order program and the member will receive up to a ninety (90)-day supply for two and one-half (2 ½) regular copayments.

(II) Specialty drugs covered only through network mail order for up to thirty (30) days. Copayments:

(a) Generic: six dollars and sixty-seven cents ($6.67);

(b) Formulary brand: twenty-nine dollars and seventeen cents ($29.17); and

(c) Non-formulary: forty-five dollars and eighty-three cents ($45.83).

2. Non-network pharmacies—If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable copayment. All such claims must be filed within twelve (12) months of the incurred expense.

3. Retail prescription drugs—Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.

(2) If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug rather than the copayment.

(3) Retail and mail order coverage includes the following (except for specialty drugs):

(A) Diabetic supplies, including—

1. Insulin;
2. Syringes;
3. Test strips;
4. Lancets; and
5. Glucometers;

(B) Prescribed vitamins, excluding those vitamins that may be purchased over-the-counter;

(C) Prescribed self-injectables;

(D) Oral chemotherapy agents;

(E) Hematopoietic stimulants;

(F) Growth hormones with prior authorization;

(G) Infertility drugs—subject to fifty percent (50%) member coinsurance; and

(H) Tobacco cessation prescriptions—subject to formulary restrictions and limited to five-hundred dollar ($500) annual benefit.

(4) Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. This program involves the member's physician and is only for members who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a first step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first step drug, the physician may request a prior authorization from the pharmacy plan administrator. If the prior authorization is approved, the member is responsible for the applicable copayment which may be higher than the first step drug. If the requested prior authorization is not approved, then the member is responsible for the full price of the drug.

(A) First Step—

1. Uses primarily generic drugs;
2. Lowest applicable copayment is charged; and
3. First step drugs must be used before the plan will authorize payment for second step drugs.

(B) Second Step—

1. This step applies if the member's treatment plan requires a different medication after attempting the first step medication;
2. Uses primarily brand-name drugs; and

3. Typically, a higher copayment amount is applicable.

(5) Prior Authorization—Certain medications are subject to prior authorization. Network pharmacies will notify the member if prior authorization is required. The member or the pharmacy must contact the pharmacy plan administrator before payment will be approved.

(6) Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. Members may request claim forms from the plan or the pharmacy plan administrator. In order to file a claim, members must—

(A) Complete the claim form; and

(B) Attach a prescription receipt or label with the claim form. Patient history printouts from the pharmacy are acceptable but must be signed by the pharmacist. Cash register receipts are not acceptable for any prescriptions, except diabetic supplies. If attaching a receipt or label, the receipt or label shall include—

1. Pharmacy name and address;
2. Patient's name;
3. Price;
4. Date filled;
5. Drug name, strength, and national drug code (NDC);
6. Prescription number;
7. Quantity; and
8. Days supply.

(7) Formulary—The formulary does not change during a calendar year, unless—

(A) A generic drug becomes available to replace the brand-name drug. If this occurs, the generic copayment applies; or

(B) A drug becomes available over-the-counter. If this occurs, then the drug is no longer covered under the pharmacy benefit; and

(C) A drug is determined to have a safety issue.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. Emergency rescission filed Dec. 21, 2006, effective Jan. 1, 2007, expired June 29, 2007. Rescinded: Filed Dec. 21, 2006, effective June 30, 2007. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Readopted: Filed Jan. 4, 2010.

PUBLIC COST: This proposed rule will cost the Missouri Consolidated Health Care Plan $67,773,864 annually in the aggregate.

PRIVATE COST: This proposed rule will cost private entities $19,425,264 annually in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 2

Rule Number and Name:	22 CSR 10-2.090 Pharmacy Benefit Summary
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan	**$ 67,773,864**

III. WORKSHEET

Estimated cost is the annual cost of the MCHCP providing pharmacy benefits to all state employees and eligible retirees and dependents who enrolled for coverage under an MCHCP plan for calendar year 2010.

IV. ASSUMPTIONS

- **Total enrollment under MCHCP Plans as of December 14, 2009 (data used the CY2010 projection);**
- **Calendar year 2010 membership in all MCHCP Plans would remain relatively stable;**
- **Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary;**
- **Actual costs will vary based upon actual utilization of services.**

FISCAL NOTE
PRIVATE COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 2

Rule Number and Title:	**22 CSR 10-2.090 Pharmacy Benefit Summary**
Type of Rulemaking:	**Proposed Rule**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
106,070 individuals enrolled in the MCHCP Plans for CY 2010	**Individuals enrolled in the MCHCP Plans for CY 2010**	**$ 19,425,264**

III. WORKSHEET

Estimated cost is the annual cost for all MCHCP subscribers' premium costs for pharmacy coverage for calendar year 2010. In addition, members will pay the following copayments based upon their individual utilization of covered benefits:

- $8 copayment for up to a 30-day supply of generic medication obtained at retail pharmacy
- $35 copayment for up to a 30-day supply of formulary medication obtained at retail pharmacy
- $55 copayment for a 30-day supply of non-formulary medication obtained at retail pharmacy
- $20 copayment for up to a 90-day supply of generic medication obtained at mail order pharmacy
- $87.50 copayment for up to a 90-day supply of formulary medication obtained at mail order pharmacy
- $137.50 copayment for a 90-day supply of non-formulary medication obtained at mail order pharmacy

IV. ASSUMPTIONS

- Total enrollment in the MCHCP pharmacy plan as of December 14, 2009 (data used for the CY2010 projection);

- Calendar year 2010 membership in the MCHCP pharmacy plan would remain relatively stable;
- Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.010 Definitions. The Missouri Consolidated Health Care Plan is amending the purpose and section (1) and breaking it into new sections and adding several new sections.

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the definitions of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule establishes the policy of the board of trustees [regarding] ***in regard to*** *the [key terms within]* ***definitions of*** *the Missouri Consolidated Health Care Plan relative to public entities and public entity members.*

[(1) When used in this chapter's rules or the public entity member handbook, these words and phrases have the meaning—]

*[(A)]***(1)** Accident*[—An unexpected happening resulting in an injury which is not due to any fault or misconduct on the part of the person injured;]***. An unforeseen and unavoidable event resulting in an injury which is not due to any fault or misconduct on the part of the person injured.**

[(B) Actively at work—You are considered actively at work when performing in the customary manner all of the regular duties of your occupation with the employer either at one (1) of the employer's regular places of business or at some location which the employer's business requires you to travel to perform your regular duties or other duties assigned by your employer. You are also considered to be actively at work on each day of a regular paid vacation or nonworking day on which you are not totally disabled, but only if you are performing in the customary manner all of the regular duties of your occupation with the employer on the immediately preceding regularly scheduled workday;]

(2) Administrative appeal. A written request submitted by or on behalf of a member involving plan-related administrative issues such as eligibility, effective dates of coverage, plan changes, etc.

*[(C)]***(3)**Administrative guidelines*[—The]***. Instructive** interpretation of the plan document *[as approved by the plan administrator,]* developed for administration of the plan. The administrative guidelines may be changed upon approval of the executive director or his/her designee. Benefits provided shall be those in effect at the time services are rendered*[;]***.**

[(D) Automatic reinstatement maximum—The maximum annual amount that can be reinstated to an individual's lifetime benefit;

(E) Benefit year—The twelve (12)-month period beginning January 1 and ending December 31;]

(4) Adverse determination. When the claims administrator reviews an admission, availability of care, continued stay, or other health care service and decides that it is not medically necessary, appropriate, or effective. Therefore, payment for the requested service is denied, reduced, or terminated.

(5) Allowable expense. Charges for services rendered or supplies furnished by a health plan that would qualify as covered expenses and for which the program pays in whole or in part, subject to any deductible, coinsurance, or table of allowance included in the program.

(6) Appeal. A written complaint submitted by or on behalf of a member regarding one (1) of the following:

(A) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or

(B) Claim payment, handling, or reimbursement for pharmacy benefits or health care services.

(7) Benefit period. The three hundred sixty-five (365) days immediately following the first date of like services.

*[(F)]***(8)** Benefits*[—]***.** Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator*[;]***.**

[(G) Care Support Program—A voluntary program that helps manage a chronic condition with outpatient treatment;]

(9) Birthday rule. If both parents have medical coverage, the primary plan for dependent children is the plan of the parent whose birthday occurs first in the calendar year. If birthdays occur on the same day, the parent's coverage that has been in effect longest is primary.

(10) Board. The board of trustees of the Missouri Consolidated Health Care Plan.

(11) Calendar year. The period of time from January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All annual deductibles and benefit maximums accumulate during the calendar year.

(12) Chiropractic services. The examination, diagnosis, adjustment, manipulation, and treatment of malpositioned articulations and structures of the body, directed toward restoring and maintaining the normal neuromuscular and musculoskeletal function and health.

*[(H)]***(13)** Claims administrator*[—]***.** An organization or group responsible for the processing of claims and associated services for the plan's self-insured benefit programs *[and preferred provider organization (PPO);]***, including but not limited to the preferred provider organization (PPO) (also known as the copay plan) and health maintenance organization (HMO) type plans.**

(14) Coinsurance. The shared portion of payment between the plan and the subscriber where each pays a percentage of covered charges.

(15) Comprehensive major medical. A plan that provides for cost sharing to be applied to all covered expenses such as deductible or coinsurance.

(16) Congenital defect. Existing or dating from birth. Acquired through development while in the uterus.

(17) Convenient care clinics (CCCs). Health care clinics located in retail stores, supermarkets, and pharmacies that treat routine family illnesses and provide preventive health care services. They are sometimes referred to as "retail-based clinics" or "walk-in medical clinics." CCCs are usually staffed by nurse practitioners or physician assistants. Some CCCs, however, are staffed by physicians.

(18) Coordination of benefits. Communication, adjustment, and reconciliation procedures between multiple benefit plans covering the same member for purposes of covering services and expenses relating to plan benefits.

(19) Copay plan. A set of benefits similar to a health maintenance organization option.

(20) Copayment. A set dollar amount that the covered individual must pay for specific services.

*[(I)]***(21)** Cosmetic surgery*[—]***.** A procedure performed primarily **for psychological purposes or** to preserve or improve appearance rather than restore the anatomy and/or function of the body which are lost or impaired due to illness or injury*[;]***.**

*[(J)]***(22)** Covered benefits **and charges.** *[—]* A schedule of covered services and charges*[, including chiropractic services, which are]* payable under the plan*[;]***. The benefits covered under each type of plan are outlined in the applicable rule in this chapter.**

*[(K)]***(23)** Custodial care**.** *[—Care designed essentially to assist an individual to meet the activities of daily living; for example, assistance in bathing, supervision of medication which can usually be self-administered and which does not entail or require the continuing attention of trained medical or paramedical personnel;]* **Services and supplies furnished primarily to assist an individual to meet the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a health care provider or that do not entail and require the continuing attention of trained medical or paramedical personnel.**

(24) Date of service. Date medical services are received or performed.

(25) Deductible. The amount of expense the member must pay before the plan begins to pay for covered services and supplies. This amount is not reimbursable by the plan.

*[(L)]***(26)** Dependent-only participation*[—]***.** Participation of certain survivors of *[employees]* **subscribers**. Dependent participation may be further defined to include the deceased *[employee's]* **subscriber's**:

*[1)]***(A)** *[s/***S**pouse only;

*[2)]***(B)** *[c/***C**hild(ren) only; or

*[3)]***(C)** *[s/***S**pouse and child(ren)*[;]***.**

*[(M)]***(27)** Dependents*[—]***.** The lawful spouse of the employee, the employee's unemancipated child(ren)**,** and certain survivors of employees, as provided in the plan document and these rules, for whom application has been made and has been accepted for participation in the plan*[;]***.**

(28) Diagnostic charges. The Usual, Customary, and Reasonable (UCR) charges or the network discounted rate (NDR) for x-ray or laboratory examinations made or ordered by a physician in order to detect a medical condition.

(29) Disposable supplies. Medical supplies that do not withstand prolonged use and are periodically replaced. Includes, but not limited to, colostomy and ureterostomy bags.

(30) Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:

(A) Doctor of medicine;

(B) Doctor of osteopathy;

(C) Podiatrist;

(D) Optometrist;

(E) Chiropractor;

(F) Psychologist;

(G) Doctor of dental surgery; or

(H) Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practice of spiritual healing are well established and recognized.

(31) Durable medical equipment (DME). Equipment able to withstand repeated use for the therapeutic treatment of an active illness or injury. Such equipment is not covered under the plan if it could be useful to a person in the absence of an illness or injury and could be purchased without a physician's prescription.

*[(N)]***(32)** Eligibility date*[—]***.** Refer to 22 CSR 10-3.020 for effective date provisions. *[1.]* Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of eligibility as determined by the employer.

*[(O)]***(33)** Emancipated child(ren)*[—]***.** A child(ren) who is—

*[1.]***(A)** Employed on a full-time basis;

*[2.]***(B)** Eligible for group health benefits in his/her own behalf;

*[3.]***(C)** Maintaining a residence separate from his/her parents or guardian—except for full-time students in an accredited school or institution of higher learning; or

*[4.]***(D)** Married*[;]***.**

(34) Emergency. Any medical condition leading a prudent layperson to seek immediate medical attention. This normally means the sudden onset of a health condition that manifests itself by acute symptoms and severity (including severe pain). Examples of medical emergencies include, but are not limited to:

(A) Conditions placing a person's health in significant jeopardy;

(B) Serious impairment to a bodily function;

(C) Serious dysfunction of any bodily organ or part;

(D) Inadequately controlled pain; or

(E) Situations when the health of a pregnant woman or her unborn child are threatened.

(35) Emergency room. The section of a hospital equipped to furnish emergency care to prevent the death or serious impairment of the covered person.

*[(P)]***(36)** Employee and dependent participation*[—]***.** Participation of an employee and the employee's eligible dependents. *[Dependent participation may be further defined to include the participating employee's: 1) spouse only; 2) child(ren) only; or 3) spouse and child(ren).]* Any individual eligible for participation as an employee is not eligible as a dependent, except as noted in 22 CSR 10-3.030(1)(A)*[9.;]***7. Dependent participation may be further defined to include the participating employee's:**

(A) Spouse only;

(B) Child(ren) only; or

(C) Spouse and child(ren).

[(Q) Employee only participation. Participation of an employee without participation of the employee's dependents, whether or not the employee has dependents;]

*[(R)]***(37)** Employees*[—]***.** Employees of the participating public entity and present and future retirees from the participating public entity who meet the eligibility requirements as prescribed by the participating public entity*[;]***.**

*[(S)]***(38)** Employer*[—]***.** The public entity that employs the eligible employee as defined above*[;]***.**

*[(T)]***(39)** Executive director*[—]***.** The *[administrator]* **chief executive officer** of the Missouri Consolidated Health Care Plan (MCHCP) who *[reports directly to the plan administrator;]* **shall have charge of the offices, records, and employees of the plan, subject to the direction of the board.**

(40) Experimental/Investigational/Unproven. A treatment, procedure, device, or drug that meets any of the criteria listed below is considered experimental/investigational/unproven and is not eligible for coverage under the plan. Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community. Experimental/investigational/unproven is defined as a treatment, procedure, device, or drug that the plan administrator determines, in the exercise of its discretion:

(A) Has not received the approval of the U.S. Food and Drug Administration for marketing the drug or device at the time it is furnished, if such approval is required by law;

(B) Is shown by reliable evidence to be the subject of ongoing Phase I clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or

(C) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficiency as compared with the standard means of treatment or diagnosis.

(41) First eligible. The first thirty-one (31)-day period after a member's employment date in which the member and his/her dependents may enroll in an MCHCP plan. As a member acquires new dependents, his/her first eligible period is the first thirty-one (31) days from the date the dependent meets the eligibility requirements for coverage under the plan.

(42) Formulary. A list of drugs covered by the pharmacy program claims administrator and as allowed by the plan administrator.

(43) Generic drug. A chemical equivalent of a brand-name drug with an expired patent. The color or shape may be different, but the active ingredients must be the same for both.

(44) Grievance. A written complaint submitted by or on behalf of a member regarding either:

(A) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or

(B) Claims payment, handling, or reimbursement for health care services.

(45) Group health plan. A plan maintained by an employer or an employee organization to provide medical care or other health services, directly or indirectly, to employees, former employees, and their families, including but not limited to Medicare and Medicaid plans.

(46) Handbook. The summary plan document prepared for members explaining the terms, conditions, and all material aspects of the plan and benefits offered under the plan, a copy of which is incorporated by reference into this rule. The full text of material incorporated by reference will be made available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, 2010 State Member Handbook (January 1, 2010). It does not include any later amendments or additions.

[(U) Health maintenance organization (HMO)—An organization that provides for a wide range of comprehensive health care services for a specified group at a fixed periodic prepayment;]

(47) Health savings account (HSA). A tax-advantaged savings account that may be used to pay current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA. HSA funds can be used to help pay the deductible, coinsurance, and any qualified medical expenses not covered by the health plan.

(48) High Deductible Health Plan (HDHP). A health plan with higher deductibles than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

*[(V)]***(49)** Home health agency*[—]***.** An agency certified by **Medicare and** the Missouri Department of Health and Senior Services, or any other state's licensing or certifying body, to provide health care services to persons in their homes*[;]***.**

*[(W)]***(50)** Hospice*[—A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill;]***. A public agency, private organization, or a subdivision of either that primarily engages in providing care to terminally ill individuals, meets the conditions of participation for hospices, holds a valid Medicare provider agreement, and is licensed pursuant to state law.**

(51) Hospice facility. A public or private organization, certified by Medicare and any other state's licensing or certifying body, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill. The facility must have an interdisciplinary medical team consisting of at least one (1) physician, one (1) registered nurse, one (1) social worker, one (1) volunteer, and a volunteer program. A hospice facility is not a facility, or part thereof, which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics, or a hotel or similar institution.

*[(X)]***(52)** Hospital.

*[1.]***(A)** An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic**,** and surgical facilities, all of which must be provided on its premises, under the supervision of a staff of one (1) or more physicians and with twenty-four (24)-hour-a-day nursing service by a registered nurse (RN) on duty or call.

*[2.]***(B)** An institution not meeting all the requirements of *[(1)(X)1. of this rule]* **(52)(A) above**, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

*[3.]***(C)** An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of Public Law 89-97).

*[4.]***(D)** A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.

*[5.]***(E)** A residential alcoholism, chemical dependency**,** or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction.

(F) In no event shall the term hospital include a skilled nursing facility or any institution**,** or part thereof**,** which is used primarily as a skilled nursing facility, nursing home, rest home**,** or facility for the aged*[;]***.**

(53) Hospital copayment. Set dollar amount a subscriber must pay for each hospital admission.

(54) Hospital room charges. The hospital's most common charge for semi-private accommodations, or the most common charge for a private room if that is the only type of room available or if a private room has been recommended by a physician and approved by the claims administrator or the plan administrator.

(55) Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered as any other illness.

(56) Incident. A definite and separate occurrence of a condition.

(57) Infertility. Any medical condition causing the inability or diminished ability to reproduce.

(58) Infertility services. Services including confinement, treatment, or other services related to the restoration of fertility or the promotion of conception.

(59) Injury. A condition that results independently of an illness and all other causes and is a result of an external force or accident.

(60) Inpatient. Confined to a registered bed. Patient in hospital, skilled nursing facility, hospice facility, or free-standing chemical dependency treatment center.

(61) Legend. Any drug that requires a prescription from either a physician or a practitioner, under either federal or applicable state law, in order to be dispensed.

(62) Life events. Events occurring in an individual's life to include: marriage, birth, adoption, or placement of children.

*[(Y)]***(63)** Lifetime*[—]***.** The period of time *[you or your]* **a member or the member's** eligible dependents participate in the plan*[;]***.**

(64) Lifetime maximum. The maximum amount payable by a medical plan during a covered member's life.

*[(Z)]***(65)** Medical benefits coverage*[—]***.** Services that are received from providers recognized by the plan and are covered benefits under the plan*[;]***.**

*[(AA)]***(66)** Medically necessary*[—Services and/or supplies usually rendered or prescribed for the specific illness or injury;]***. Treatments, procedures, services, or supplies that the plan administrator determines, in the exercise of its discretion:**

(A) Are expected to be of clear clinical benefit to the patient;

(B) Are appropriate for the care and treatment of the injury or illness in question; and

(C) Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service, or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a provider has prescribed, ordered, or recommended a treatment, procedure, service, or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service, or supply must not be specifically excluded from coverage under this plan.

(67) Member. Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

(68) Morbid obesity. Body Mass Index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions approved by the plan administrator based on clinical review.

(69) Network provider. A physician, hospital, pharmacy, etc., that is contracted with the plan.

(70) Non-embedded deductible. The family deductible that must be met before claim payments begin, applicable when two (2) or more family members are covered in the HDHP.

(71) Non-formulary. A drug not contained on the pharmacy program's formulary list but may be covered under the terms and conditions of the plan.

(72) Non-network provider or non-participating provider. Any physician, hospital, pharmacy, etc., that does not have a contract with the plan.

*[(BB)]***(73)** Nurse*[—]***.** A registered nurse (RN), licensed practical nurse (LPN)**,** or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule*[;]***.**

(74) Nursing home. An institution operated, pursuant to law, primarily for custodial care or for patients convalescing from illness or injury, under the supervision of a physician or registered nurse and having twenty-four (24)-hour nursing care. Also, an institution meeting the preceding criteria which is established for the treatment of sick and injured persons through spiritual means and is operated under the authority of organizations which are recognized under Medicare.

*[(CC)]***(75)** Open enrollment period*[—]***.** A period designated by the plan during which subscribers may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year*[;]***.**

*[(DD)]***(76)** Out-of-area*[—]***.** Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria*[;]***.**

*[(EE)]***(77)** Out-of-network*[—]***.** Providers that do not participate in the member's health **or pharmacy** plan*[;]***.**

(78) Out-of-pocket maximum. The maximum amount the member must pay before the plan begins paying one hundred percent (100%) of covered charges for the remainder of the calendar year.

(79) Outpatient. Treatment either outside a hospital setting or at a hospital when room and board charges are not incurred.

(80) Outpatient observation stay. Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need

for a possible admission to the hospital as an inpatient. Most observation services are less than twenty-four (24) hours. Members may receive observation services in the emergency room, an observation unit, the intensive care unit, or a regular floor.

(81) Palliative services. Care provided by a team approach that improves the quality of life for patients and their families facing problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

(82) Partial hospitalization. A distinct and organized intensive ambulatory treatment service, less than twenty-four (24)-hour daily care specifically designed for the diagnosis and active treatment of a mental/nervous disorder when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.

(A) Partial hospitalization programs must provide diagnostic services; services of social workers; psychiatric nurses and staff trained to work with psychiatric patients; individual, group, and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions for therapeutic purposes.

(B) The facility providing the partial hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a physician.

*[(FF)]***(83)** Participant*[—]***.** Any employee or dependent accepted for membership in the plan*[;]***.**

(84) Pharmacy benefit manager (PBM). Acts as a link between the parties involved in the delivery of prescription drugs to health plan members. The PBM designs, implements, and manages the overall drug benefit of the plan and processes claims payments.

*[(GG)]***(85)** Physically or mentally disabled*[—]***.** The inability of a person to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition*[;]***.**

*[(HH)]***(86)** Physician/Doctor*[—]***.** A licensed practitioner of the healing arts, acting within the scope of his/her practice as licensed under section 334.021, RSMo*[;]***.**

*[(II)]***(87)** Plan*[—]***.** The program of health care benefits established by the trustees of the Missouri Consolidated Health Care Plan as authorized by state law*[;]***.**

*[(JJ)]***(88)** Plan administrator*[—]***.** The trustees of the Missouri Consolidated Health Care Plan*[;]***. As such, the board is the sole fiduciary of the plan, has all discretionary authority to interpret its provisions and to control the operation and administration of the plan, and whose decisions are final and binding on all parties.**

*[(KK)]***(89)** Plan document*[—]***.** The statement of the terms and conditions of the plan as *[adopted by the plan administrator in the "2005 Missouri Consolidated Health Care Plan Public Entity Employee Member Handbook" with respect to dental and vision coverage and incorporated by reference in this rule, as published in August 2004 by the Missouri Consolidated Health Care Plan, PO Box 104355, Jefferson City, MO 65110. This rule does not incorporate any subsequent amendments or additions. Note: The plan documents for medical plans are provided by the fully-insured contractors of such plans, and such plan documents may be obtained by contacting those contractors directly. The names, addresses, and phone numbers of the fully-insured contractors may be found in the "2005 Missouri Consolidated Health Care Plan Public Entity Employee Member Handbook";]* **promulgated by the plan administrator in this chapter.**

*[(LL)]***(90)** Plan year*[—]***.** Same as *[benefit]* **calendar** year*[;]***.**

[(MM) Point-of-service (POS)—A plan which provides a wide range of comprehensive health care services, like an HMO, if in-network providers are utilized, and like a PPO plan, if non-network providers are utilized;

(NN) Pre-admission testing—X-rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission;]

(91) Pre-admission testing. X-rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission.

(92) Pre-certification. Also known as pre-admission certification, pre-admission review, and pre-certification. The process of obtaining certification or authorization from the plan for routine hospital admissions and surgical or diagnostic procedures (inpatient or outpatient).

(93) Pre-existing condition. A condition for which a member has incurred medical expenses or received treatment prior to the effective date of coverage.

*[(OO)]***(94)** Preferred provider organization (PPO)*[—]***.** An arrangement with providers where discounted rates are given to members of the plan who, in turn, are offered a financial incentive to use these providers*[;]***.**

(95) Prevailing fee. The fee charged by the majority of dentists.

(96) Primary care physician (PCP). A physician (usually an internist, family/general practitioner, or pediatrician) who has contracted with and been approved by a medical plan.

(97) Prior authorization. A cost control procedure that requires the service or medication to be approved in advance by the doctor and/or the plan. Without prior authorization, the plan may not pay for the test, drug, or service. Also known as pre-authorization or pre-notification.

*[(PP)]***(98)** Prior plan*[—]***.** The terms and conditions of a plan in effect for the period preceding coverage in the *[MCHCP;]* **plan.**

(99) Private duty nursing. Private duty nursing services, nursing care on a full-time basis in the member's home, or home health aides.

(100) Proof of eligibility. Documentation required by the plan to determine a dependent's qualification for health insurance coverage.

(101) Proof of insurance. Evidence in written form from an insurance company that provides verification of coverage for a given period of time.

(102) Proof of prior coverage. If a member or his/her dependents enroll in an MCHCP plan due to loss of coverage, the member must provide proof of prior group coverage. This includes a letter from the previous insurance carrier or former employer which states all the following:

(A) Date coverage was or will be terminated;

(B) Reason for coverage termination; and
(C) List of dependents covered.

(103) Prostheses. An artificial extension that replaces a missing part of the body. Prostheses are typically used to replace parts lost by injury (traumatic) or missing from birth (congenital) or to supplement defective parts.

(104) Protected health information. Any information, whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse. This information also relates to the past, present, or future physical or mental health or condition of the individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to the individual.

*[(QQ)]***(105)** Provider*[—]***.** Hospitals, physicians, chiropractors, medical agencies, or other specialists who provide medical care within the scope of his/her practice and are recognized under the provisions *[and administrative guidelines]* of the plan. Provider also includes a qualified practitioner of an organization which is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized*[;]***.**

(106) Provider directory. A listing of network providers within a health plan.

(107) Prudent layperson. An individual possessing an average knowledge of health and medicine.

*[(RR)]***(108)** Public entity*[—]***.** A state-sponsored institution of higher learning, political subdivision**,** or governmental entity or instrumentality that has elected to join the plan and has been accepted by the board*[;]***.**

(109) Qualified Medical Child Support Order (QMCSO). A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or an enrollee if the plan normally provides coverage for dependent children.

(110) Reconstructive surgery. A procedure performed to restore the anatomy and/or functions of the body that are lost or impaired due to an injury or illness.

(111) Refractions. A record of the patient's preference for the focusing of the eyes that can then be used to purchase eyeglasses. It is the portion of the eye exam that determines what prescription lens provides the patient with the best possible vision.

(112) Rehabilitation facility. A legally operating institution, or distinct part of an institution, that has a transfer agreement with one (1) or more hospitals and is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute hospital, and rehabilitative inpatient care, and is duly licensed by the appropriate government agency to provide such services.

(A) It does not include institutions that provide only minimal care, custodial care, ambulatory or part-time care services, or an institution that primarily provides treatment of mental/nervous disorders, substance abuse, or tuberculosis, except if such facility is licensed, certified, or approved as a rehabilitation facility for the treatment of mental/nervous conditions or substance abuse in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) or the Commission for the Accreditation of Rehabilitation Facilities.

(113) Retiree. A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-3.020(6)(B) and is currently receiving a monthly retirement benefit from one (1) of the retirement systems listed in such rule.

[(SS) Review agency—A company responsible for administration of clinical management programs;]

*[(TT)]***(114)** Second opinion program*[—]***.** A consultation and/or exam with a physician qualified to perform the procedure who is not affiliated with the attending physician/surgeon, for the purpose of evaluating the medical necessity and advisability of undergoing a surgical procedure or receiving a service*[;]***.**

(115) Skilled nursing care. Care which must be performed by, or under the supervision of, licensed personnel and meets criteria as established by the claims administrator.

*[(UU)]***(116)** Skilled nursing facility (SNF)*[—]***.** An institution which meets fully each of the following requirements:

*[1.]***(A)** It is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, the following services for persons convalescing from sickness or injury: room, board**,** and twenty-four (24)-hour-a-day nursing service by one (1) or more professional nurses and nursing personnel as are needed to provide adequate medical care;

*[2.]***(B)** It provides the services under the supervision of a proprietor or employee who is a physician or registered nurse; and it maintains adequate medical records and has available the services of a physician under an established agreement, if not supervised by a physician or registered nurse; and

*[3.]***(C)** A skilled nursing facility shall be deemed to include institutions meeting the criteria in *[subsection (1)(UU) of]* this rule which are established for the treatment of sick and injured persons through spiritual means and are operated under the authority of organizations which are recognized under Medicare (Title I of Public Law 89-97)*[;]***.**

(117) Sound natural teeth. Teeth and/or tissue that is viable, functional, and free of disease. A sound natural tooth has no decay, fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.

(118) Specialty care physician/specialist. A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

(119) Specialty medications. High cost drugs that are primarily self-injectible but sometimes oral medications.

*[(VV)]***(120)** State*[—]***.** Missouri*[;]***.**

(121) Step therapy. Designed to encourage use of therapeutically-equivalent, lower-cost alternatives before stepping up to more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

(122) Subrogation. The substitution of one (1) "party" for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan

to stand in the place of the participant and recover the money directly from the other insurer.

*[(WW)]***(123)** Subscriber*[—]***.** The employee or member who elects coverage under the plan*[;]***.**

(124) Subscriber only participation. Participation of a subscriber without participation of the subscriber's dependents, whether or not the subscriber has dependents.

(125) Surgery. Any operative or invasive diagnostic procedure performed in the treatment of an injury or illness by an instrument or cutting procedure through any natural body opening or incision.

(126) Surgery center (ambulatory). A hospital based, sponsored, or independently-owned facility that performs surgery.

*[(XX)]***(127)** Survivor*[—]***.** A member who meets the requirements of **subsection** 22 CSR 10-3.020(6)(A)*[;]***.**

*[(YY)]***(128)** Unemancipated child(ren). A natural child(ren), a legally adopted child(ren) or a child(ren) placed for adoption, and a dependent disabled child(ren) over twenty-five (25) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:

*[1.]***(A)** Stepchild(ren);

*[2.]***(B)** Foster child(ren) for whom the employee is responsible for health care;

*[3.]***(C)** Grandchild(ren) for whom the employee has legal custody and is responsible for providing health care; **and**

*[4.]***(D)** Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator.

(E) Except for a disabled child(ren) as described in *[sub]*section *[(1)(GG)]***(85)** of this rule, an unemancipated child(ren) is eligible from birth to the end of the month in which s/he is emancipated, as defined here, or attains age twenty-five (25) (see **paragraph** 22 CSR 10-3.020(4)(D)2. for continuing coverage on a handicapped child(ren) beyond age twenty-five (25)); and

*[5.]***(F)** Stepchild(ren) who are not domiciled with the employee, provided the natural parent who is legally responsible for providing coverage is also covered as a dependent under the plan*[;]***.**

(129) Urgent care. Medically necessary services in order to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician office but not severe enough to require treatment in a hospital emergency department.

(130) Urgent care centers. Medical facilities that provide extended or twenty-four (24)-hour service to treat minor conditions at a lower cost than emergency room treatment.

*[(ZZ)]***(131)** Usual, *[c]***C**ustomary, and *[r]***R**easonable *[c]***C**harge*[—]***.**

*[1.]***(A)** Usual—The fee a physician most frequently charges the majority of his/her patients for the same or similar services*[;]***.**

*[2.]***(B)** Customary—The range of fees charged in a geographic area by physicians of comparable skills and qualifications for the same performance of similar service*[;]***.**

*[3.]***(C)** Reasonable—The flexibility to take into account any unusual clinical circumstances involved in performing a particular service*[; and]***.**

*[4.]***(D)** A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the doctors for ninety percent (90%) of the procedures reported*[; and]***.**

(132) Utilization review. Evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities on a prospective, concurrent, or retrospective basis.

*[(AAA)]***(133)** Vested subscriber*[—]***.** A member who meets the requirements of **subsection** 22 CSR 10-3.020(6)(B).

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Emergency amendment filed Dec. 20, 2007, effective Jan. 1, 2008, expired June 28, 2008. Amended: Filed Dec. 20, 2007, effective June 30, 2008. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Amended: Filed Jan. 4, 2010.

PUBLIC COST: This proposed amendment will cost the Missouri Consolidated Health Care Plan and public entities $4,703,809 annually in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities $4,703,809 annually in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 3

Rule Number and Name:	22 CSR 10-3.010 Definitions
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003	**$4,703,809**

III. WORKSHEET

Estimated cost is the annual cost of 50 percent of the public entity premium for all public entity employees who enrolled for coverage under this plan for calendar year 2010.

IV. ASSUMPTIONS

- **Total enrollment under the all public entity plans as of January 1, 2010;**
- **Calendar year 2010 membership in the public entity plans would remain relatively stable;**
- **Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary;**
- **Calculations are based on Active Employee Only premiums and do not include dependents or retirees;**
- **Calculations are based on average premiums for all public entities;**
- **Calculations assume each public entity is contributing at least 50 percent of the premium;**
- **Calculations include pharmacy costs as outlined in 22 CSR 10-3090;**
- **Actual costs will vary based upon actual utilization of services.**

FISCAL NOTE
PRIVATE COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 3

Rule Number and Title:	**22 CSR 10-3.010 Definitions**
Type of Rulemaking:	**Proposed Amendment**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
1,648 individuals enrolled in MCHCP public entity plans for CY 2010	**Individuals enrolled in MCHCP public entity plans for CY 2010**	**$ 4,703,809**

III. WORKSHEET

Estimated cost is the annual cost of 50 percent of the public entity premium for all public entity employees who enrolled for coverage under this plan for calendar year 2010.

IV. ASSUMPTIONS

- Total enrollment under all public entity plans as of January 1, 2010;
- Calendar year 2010 membership in the all public entity plans would remain relatively stable;
- Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Calculations are based on Active Employee Only premiums and do not include dependents or retirees;
- Calculations are based on average premiums for all public entities;
- Calculations assume each public entity is contributing at least 50 percent of the premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3090;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.020 Subscriber Agreement and General Membership Provisions. The Missouri Consolidated Health Care Plan is amending the purpose and sections (1), (3), (4), and (6)–(9).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the subscriber agreement and general membership provisions of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule establishes the policy of the board of trustees in regard to the [employee's] subscriber agreement and ***general*** *membership [period for participation in]* ***provisions of*** *the Missouri Consolidated Health Care Plan.*

(1) The participant's initial application, any subsequently accepted modifications to such application, **the handbook,** and the plan document as adopted by the board along with duly executed amendments shall comprise the subscriber agreement between the participant and the Missouri Consolidated Health Care Plan (MCHCP). Any *[associated administrative guidelines]* **other written materials** interpret**ing** the subscriber agreement for the benefit of members and administrators *[but]* are not part of the subscriber agreement.

(A) By applying for coverage under the MCHCP**,** a participant agrees that—

1. The employer may deduct the cost of the premium for the employee's plan from the employee's paychecks; and

2. Individual and family deductibles, if appropriate, will be applied. Deductibles previously paid to meet the requirements of the prior plan may be credited for those joining one **(1)** of the preferred provider organization (PPO) options. Appropriate proof of said deductibles will be required.

(3) The effective date of participation shall be determined, subject to the effective date provision in subsection (3)(C), as follows:

(A) Employee Participation.

1. If application by an employee is made on or before the date of eligibility, participation shall become effective on such date of eligibility;

2. If application by an employee is made within thirty-one (31) days after the date of eligibility, participation may become effective on the date of eligibility or the first day of the calendar month coinciding with or following the date *[of]* **the** application **is received**, except that participation shall be retroactive to the beginning of the month for employees rehired during the month following the month participation would have terminated; and

3. Not limiting or excluding any of the other provisions, if application is not made within thirty-one (31) days of the employee's date of eligibility, they may apply for coverage only if *[a life event occurs. Life events include: marriage, birth, adoption, death, divorce, legal separation, job loss or failure to elect continuation of coverage. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify the plan administrator of the life event;]* **one (1) of the following occurs:**

A. Occurrence of a life event which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify the plan administrator of the life event;

B. Loss of a spouse's employer-sponsored group coverage when the employee originally waived coverage through the plan. Application must be made within sixty (60) days of the time—

(I) The employee no longer qualifies for coverage under spouse's plan;

(II) The spouse's employment terminates or he/she is no longer eligible for coverage under employer's plan;

(III) The spouse's employer-sponsored medical, dental, and/or vision plan terminates;

(IV) All employer contributions toward the spouse's plan cease; or

(V) The employee's Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends; or

C. Loss of eligibility for Medicaid, in which case application for coverage through the plan must be made within sixty (60) days of the loss;

(B) Dependent Coverage. Dependent participation cannot precede the subscriber's participation **except when coverage is added as a life event with birth of a child or adoption of a child at birth. The effective date for a child is the date of birth. The subscriber and/or dependent's effective date is the first day of the calendar month coinciding with or following the date of the application**. Application for participants must be made in accordance with the following provisions*[.]***:**

1. For family coverage, once a subscriber is participating with respect to dependents, newly acquired dependents are automatically covered on their effective dates as long as the plan administrator is notified within thirty-one (31) days of the person becoming a dependent. First eligible dependents must be added within thirty-one (31) days of such qualifying event. The employee is required to notify the plan administrator on the appropriate form of the dependent's name, date of birth, eligibility date**,** and Social Security number, if available. Claims will not be processed until the required information is provided*[.]***;**

*[1.]***2.** If an employee makes concurrent application for dependent participation on or before the date of eligibility or within thirty-one (31) days thereafter, participation for dependent will become effective on the date the employee's participation becomes effective;

*[2.]***3.**When an employee participating in the plan first becomes eligible with respect to a dependent child(ren), coverage may become effective on the eligibility date or the first day of the month coinciding with or following the date of eligibility if application is made within thirty-one (31) days of the date of eligibility and provided any required contribution for the period is made; **and**

[3. Unless required under federal guidelines—

A. An emancipated dependent who regains his/her dependent status is immediately eligible for coverage if an application is submitted within thirty-one (31) days of regaining dependent status; and

B. An eligible dependent that is covered under a spouse's health plan who loses eligibility under the criteria stipulated for dependent status under the spouse's health plan is not eligible for coverage until the next open enrollment period. (Note: Subparagraphs (3)(B)3.A. and B. do not include dependents of retirees or long-term disability members covered under the plan); and]

4. Survivors, retirees, vested subscribers**,** and long-term disability subscribers may only add dependents to their coverage when the dependent is first eligible for coverage*[;]***, except when a dependent's employer-sponsored coverage ends due to one (1) of the following:**

A. Termination of employment;

B. Retirement; and

C. Termination of group coverage by the employer.

Coverage must have been in place for twelve (12) months immediately prior to the loss, and coverage must be requested within sixty (60) days from the termination date of the previous coverage;

(C) Effective Date *[Proviso]* **Provision**.

1. In any instance when the employee is not actively working full-time on the date participation would otherwise have become effective, participation shall not become effective until the date the employee returns to full-time active work. However, this provision shall not apply for public entities (or any individual who is a member of that public entity) when the MCHCP is replacing coverage for that public entity;

[(D) Application for dependent coverage may be made at other times of the year when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's: 1) employment is terminated or is no longer eligible for coverage under his/her employer's plan, or 2) employer-sponsored medical plan is terminated. With respect to dependent child(ren) coverage, application may also be made at other times of the year when the member receives a court order stating s/he is responsible for providing medical coverage for the dependent child(ren) or when the dependent loses Medicaid coverage. Dependents added under any of these exceptions must supply verification from the previous insurance carrier or the member's employer that they have lost coverage and the effective date of termination. Coverage must also be requested within sixty (60) days from the termination date of the previous coverage. Application must be made within sixty (60) days of the court order. (Note: This section does not include dependents of retirees, survivors, vested subscribers, or long-term disability subscribers covered under the plan); and

(E) When an employee experiences applicable life events, eligibility will be administered according to Health Insurance Portability and Accountability Act (HIPAA) guidelines.]

(D) Application for dependent coverage may be made within sixty (60) days when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's:

1. Employer-sponsored medical plan terminates or coverage by the employer is no longer offered;

2. The employer contributions toward the premiums cease; or

3. A dependent no longer qualifies due to age;

(E) Application may be made for dependent coverage within sixty (60) days of the event—

1. A Qualified Medical Child Support Order is received;

2. A dependent no longer qualifies for Medicaid; or

(F) Application may be made for dependent coverage within thirty-one (31) days of an emancipated dependent regaining dependent status.

(4) Termination of participation shall occur on the last day of the calendar month coinciding with or following the happening of any of the following events, whichever shall occur first:

(D) Termination of Eligibility for Participation.

1. With respect to employees, termination of participation shall occur upon termination of employment in a position covered by the MCHCP, except as specified in sections (5) and (6).

2. With respect to dependents, termination of participation shall occur upon ceasing to be a dependent as defined in this rule with the following exception: unemancipated mentally *[retarded]* and/or physically handicapped children will continue to be eligible beyond age twenty-five (25) during the continuance of a permanent disability provided documentation satisfactory to the plan administrator is furnished by a physician prior to the dependent's twenty-fifth birthday, and as requested at the discretion of the plan administrator.

3. Termination of employee's participation shall terminate the participation of dependents, except as specified in section (6).

(6) Continuation of Coverage.

(A) Dependents. Termination of an active employee's participation by reason of death shall not terminate participation with respect to the surviving spouse and/or dependent children if *[—]*

*[1. T]***t**he active employee was vested and eligible for a future retirement benefit*[; or]* **and**

[2. Your] eligible dependents meet one (1) of the following conditions:

*[A.]***1.** They have had coverage through MCHCP since the effective date of the last open enrollment period;

*[B.]***2.** They have had other health insurance for the six (6) months immediately prior to *[your]* **the employee's** death—proof of insurance is required; or

*[C.]***3.** They have had coverage through MCHCP since they were first eligible.

(B) Employee Eligible for Retirement Benefits. Any employee who, at the time of termination of employment, met the following—

1. Eligibility Criteria:

A. Coverage through MCHCP since the effective date of the last open enrollment period;

B. Other health insurance for the six (6) months immediately prior to the termination of state employment—proof of insurance is required; or

C. Coverage since first eligible;

2. Immediately eligible to receive a monthly retirement benefit from the retirement system of the participating public entity may elect to continue to participate in the plan by paying the cost of plan benefits as determined by the plan administrator. An employee must apply for continued coverage within thirty-one (31) days of the first day of the month following the date of retirement. An employee, continuing coverage under this provision, may also continue coverage for eligible dependents.

A. If a member participates in the MCHCP as a vested member, his/her dependents may also participate if they meet one (1) of the following criteria:

(I) They have had coverage through MCHCP since the effective date of the last open enrollment period;

(II) They have had other health insurance for the six (6) months immediately prior to state employment termination—proof of insurance is required; or

(III) They have had coverage since they were first eligible;

3. In the case of the death of a retiree who was maintaining dependent coverage under this provision, the dependent of the deceased retiree may continue his/her participation under the plan. However, retirees, survivors, vested subscribers**,** and long-term disability subscribers and their dependents are not later eligible if they discontinue their coverage at some future time, except as noted in *[(7)(B)4.]* **paragraph (6)(B)4.**; and

4. A vested or retired member may elect to suspend their coverage upon entry into the armed forces of any country by submitting a copy of their activation papers within thirty-one (31) days of their activation date. Coverage will be suspended the first of the month following the month of activation. Coverage may be reinstated at the same level upon discharge by submitting a copy of their separation papers and a completed enrollment form within thirty-one (31) days of their separation date. Coverage will be reinstated as of the first of the month following the month of separation.

(D) Leave of Absence. An employee on approved leave of absence may elect to retain eligibility to participate in the plan by paying the required contributions. The employing department must officially notify the plan administrator of the leave of absence and any extension of the leave of absence by submitting the required form. Any employee on an approved leave of absence who was a member of the Missouri Consolidated Health Care Plan when the approved leave began, but who subsequently terminated participation in the Missouri Consolidated Health Care Plan while on leave, may recommence his/her coverage in the plan at the same level (employee only*[,]* or employee and dependents) upon returning to employment directly from the leave*[, but they will be subject to preexisting limitations, when applicable. Preexisting limitations under this provision will not apply to health maintenance organization (HMO) or point-of-service (POS) members]*. However, eligibility is terminated for those members receiving a military leave of

absence, as specified in subsection *[(5)(C)]***(4)(C)**. Coverage may be reinstated upon return from military leave *[without proof of insurability or preexisting conditions]*. However, the former member must complete an enrollment form. Coverage under this provision is effective on the first of the month coinciding with or following the employee's return to work. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date and timely requests reinstatement of coverage.

(F) Workers' Compensation. Any person who is receiving, or is entitled to receive, Workers' Compensation benefits as a result of an injury or accident sustained in employment and who was a member of the plan at the time of becoming disabled may continue his/her coverage in the plan at the same level of participation *[(employee only or employee and dependents)]* **(subscriber only or subscriber and dependents)** by paying the required contributions, if the disability occurred in the employment through which the employee qualifies for membership in the plan. Any person receiving, or entitled to receive, Workers' Compensation benefits who was a member of the plan at the time of becoming disabled as a result of an injury or accident sustained in employment through which the person qualified for membership in the plan, but who subsequently terminated participation in the plan, may recommence his/her coverage in the plan at the same level *[(employee only, or employee and dependents)]* **(subscriber only or subscriber and dependents)** upon returning to employment*[, without proving insurability]*.

(G) Reinstatement After Dismissal. If an employee is approved to return to work after being terminated as a result of legal or administrative action available as a recourse through his/her employer, s/he will be allowed to reinstate his/her medical benefit retroactively to the date of dismissal. If the employee is reinstated with back pay, s/he will be responsible for paying any contribution normally made for either his/her coverage or his/her covered dependents. *[No preexisting condition limitation will apply.]* If the employee is reinstated without back pay, s/he will be considered to have been on a leave of absence. Consequently, the employee will be responsible for making any required contribution toward the cost of his/her medical benefits. If the employee does not purchase coverage for the period between termination and reinstatement, s/he may regain the same level of coverage s/he had prior to termination. *[If the employee participates in a PPO plan, the preexisting condition limitation will apply if coverage lapsed more than sixty-three (63) days. This does not apply if the employee participates in an HMO or POS.]*

(7) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) In accordance with the COBRA, eligible employees and their dependents may continue their medical coverage after the employee's termination date.

1. Employees terminating for reasons other than gross misconduct **or receiving a reduction in the number of hours of employment** may continue coverage for themselves and their covered dependents for eighteen (18) months at their own expense.

2. A surviving spouse and dependents, not normally eligible for continued coverage, may elect coverage for up to thirty-six (36) months at their own expense.

3. A divorced spouse may continue coverage at his/her own expense for up to thirty-six (36) months if the plan administrator is notified within sixty (60) days from the date coverage would terminate.

4. Dependent spouse and/or child(ren) may continue coverage up to thirty-six (36) months if the covered employee retires and the dependent spouse/child(ren) has not been covered by the plan for two (2) years.

5. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense if the plan administrator is notified within sixty (60) days of the loss of the dependent's eligibility.

6. Employees who are disabled at termination or become disabled during the first sixty (60) days of coverage may continue coverage for up to twenty-nine (29) months.

7. Premiums for continued coverage will be one hundred two percent (102%) of the health plan rate, one hundred fifty percent (150%) if disabled. Once coverage is terminated under the COBRA provision**,** it cannot be reinstated.

8. All operations under the COBRA provision will be applied in accordance with federal regulations.

(8) Missouri State Law COBRA Wrap-Around Provisions—Missouri law provides that if *[you lose your]* **a member loses** group health insurance coverage because of a divorce, legal separation**,** or the death of *[your]* **a** spouse**,** *[you]* **the member** may continue coverage until age sixty-five (65) if: a) *[You]* **The member** continue**s** and maintain**s** coverage under the thirty-six (36)-month provision of COBRA; and b) *[You are]* **The member is** at least fifty-five (55) years old when *[your]* COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions and will have to pay all of the application premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium. The above Cancellation of Continuation Coverage also applies to COBRA wrap-around continuation.

[(9) Medicare—Participants eligible for Medicare who are not eligible for this plan as their primary plan, shall be eligible for benefits no less than those benefits for participants not eligible for Medicare. For such participants who elect to continue their coverage, benefits of this plan shall be coordinated with Medicare benefits on the then standard coordination of benefits basis to provide up to one hundred percent (100%) reimbursement for covered charges.

(A) If a participant eligible for Medicare who is not eligible for this plan as the primary plan is not covered by Medicare, an estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim submitted basis so that if, for a given claim, Medicare reimbursement was for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims; and]

*[(B)]***(9)** If any retired participants or long-term disability recipients, their eligible dependents**,** or surviving dependents eligible for coverage elect not to be continuously covered from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Emergency amendment filed Dec. 20, 2007, effective Jan. 1, 2008, expired June 28, 2008. Amended: Filed Dec. 20, 2007, effective June 30, 2008. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Amended: Filed Jan. 4, 2010.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments

*must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.030 Public Entity Membership Agreement and Participation Period. The Missouri Consolidated Health Care Plan is amending the purpose and section (1).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the Public Entity Membership Agreement and Participation Period of the Missouri Consolidated Health Care Plan.

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the [public entity's membership agreement and participation period with] **Public Entity Membership Agreement and Participation Period of** the Missouri Consolidated Health Care Plan.*

(1) The application packet, participation agreement, and confirmation notice shall comprise the membership agreement between a public entity and the Missouri Consolidated Health Care Plan (MCHCP).

(A) By applying for coverage under the MCHCP**,** a public entity agrees that—

1. The MCHCP will be the only health care offering made to its eligible members;

[2. If the public entity participated in the MCHCP during calendar year 2004 and continues to participate each year subsequent to calendar year 2004, that public entity shall only be required to contribute twenty-five dollars ($25) per month towards the employee only premium for each active employee's premium for the plan(s) offered through MCHCP during calendar years 2005 and 2006;]

*[3.]***2.** *[If the public entity did not participate in the MCHCP during calendar year 2004, that]* **The** public entity shall contribute at least fifty percent (50%) of the lowest cost employee only premium per month toward each active employee's premium for the plan(s) offered through MCHCP;

[4. Beginning January 1, 2007, all public entities shall contribute at least fifty percent (50%) of the lowest cost employee only premium per month toward each active employee's premium for the plan(s) offered through MCHCP;]

*[5.]***3.** For public entities with less than twenty-five (25) employees, the public entity shall only offer one (1) plan choice to its employees. For public entities with twenty-five (25) or more employees, the public entity may offer *[more than one (1)]* **two (2)** plans *[choice]* provided by MCHCP*[.]***;**

*[6.]***4.** For public entities with more than a total of three (3) employees, at least seventy-five percent (75%) of all eligible employees must join the MCHCP*[. For public entities with three (3) or fewer employees, a minimum of one (1) employee must join the MCHCP. For public entities with three (3) or fewer employees who fail to have one (1) employee participating in the MCHCP, MCHCP will allow the public entity up to the remainder of the period remaining in the latest participation agreement in which to attempt to meet the participation requirements before terminating for failure to meet the participation requirements]*;

*[7.]***5.** Individual and family deductibles, if applicable, will be applied. Deductibles previously paid to meet the requirements of the terminating plan may be credited for those joining *[one of the PPO options]* **MCHCP**. Appropriate proof of said deductibles will be required;

*[8.]***6.** An eligible employee is one that is not covered by another group sponsored plan;

*[9.]***7.** Any individual eligible as an employee may be covered as either an employee or dependent, but not both. Employees enrolled as dependents will not be considered as eligible employees in consideration of section (6); and

*[10.]***8.** A public entity may apply a probationary period, not to exceed applicable federal guidelines, before benefits become effective.

(B) *[Effective January 1, 2001, i]***I**n order to provide retiree coverage, any participating member agency joining MCHCP must have one **(1)** of the criteria listed below. If neither of these scenarios is applicable and no retirement plan exists, no "retirees" would exist, so there would be no retiree eligibility.

1. An established retirement plan with contributions shared by both the employee and the employer (or made by the employer only) with an established minimum vesting period. The employer must offer coverage to retirees who have met this minimum vesting period requirement.

2. An employer-sponsored (but no contribution made by employer) retirement plan in which the employee is currently participating or from which the employee is eligible to receive a benefit. In this case, in order to be considered an eligible retiree, the prospective member must have met a vesting criterion equal to Missouri State Employees' Retirement System (MOSERS). If this criterion was not met, the employer may not offer coverage to that person as a retiree.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Amended: Filed Jan. 4, 2010.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED RULE

22 CSR 10-3.045 Plan Utilization Review Policy

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan.

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program consists of four (4) parts, as described in the following:

(A) Precertification—The medical necessity of a non-emergency hospital admission, specified procedures as documented in the claims administrator's guidelines, and/or skilled nursing services provided on an inpatient basis must be prior authorized by the appropriate claims administrator. For emergency hospital admissions, the claims administrator must be notified within forty-eight (48) hours of the admission. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(B) Concurrent Review—The claims administrator will continue to monitor the medical necessity of the admission and approve the continued stay in the hospital. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(C) Large Case Management—Members who require long-term acute care may be offered the option of receiving the care, if appropriate, in a more cost-effective setting such as a skilled nursing facility or their own home. In some cases, this may require coverage for benefits that normally are not covered under the plan. These benefits may be provided through the approval of the claims administrator;

(D) Hospital Bill Audits—Certain hospital bills will be subject to review to verify that the services billed were actually provided and/or the associated billed amounts are accurate and appropriate; and

(E) Penalties—Members not complying with subsections (1)(A) and (B) of this rule may be subject to a financial penalty in connection with their covered benefits.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Original rule filed Jan. 4, 2010.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED RULE

22 CSR 10-3.050 Copay Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Copay Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

(1) Non-network deductible amount—per individual for the Copay Plan each calendar year, six hundred dollars ($600); family limit each calendar year, one thousand two hundred dollars ($1,200).

(2) Coinsurance—non-network coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once out-of-pocket maximum is reached.

(A) Coinsurance is seventy percent (70%) after deductible is met when utilizing non-network providers.

(B) The deductible is waived and claims are paid at eighty percent (80%) for the following services: home health care, infusion, durable medical equipment (DME), and audiologists.

(C) Claims may also be paid at eighty percent (80%) if the subscriber requires covered services that are not available through a network provider within fifty (50) miles of his/her home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(D) Non-network claims—are paid at seventy percent (70%) until two thousand four hundred dollars ($2,400) has been met for an individual, four thousand eight hundred dollars ($4,800) has been met for a family, of covered charges in the calendar year which are subject to coinsurance. Claims are paid at one hundred percent (100%) of any excess covered charges in the calendar year.

(3) Copayments—set charges for the following types of claims so long as network providers are utilized.

(A) Office visit—primary care: twenty-five dollars ($25); specialist: thirty-five dollars ($35).

(B) Laboratory and X-ray services—no copayment; covered at one hundred percent (100%).

(C) Inpatient hospitalizations—three hundred dollars ($300) per admission; one thousand two hundred dollars ($1,200) annual maximum inpatient copayment.

(D) Maternity—primary care: twenty-five dollars ($25) for initial visit; specialist: thirty-five dollars ($35).

(E) Preventive care—no copayment; covered at one hundred percent (100%).

(F) Outpatient surgery—one hundred dollars ($100).

(G) Emergency room—one hundred dollars ($100) network and non-network.

(H) Urgent care—thirty-five dollars ($35) network and non-network.

(4) Out-of-pocket non-network maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Non-network out-of-pocket maximum for individual—two thousand four hundred dollars ($2,400); and

(B) Non-network out-of-pocket maximum for family—four thousand eight hundred dollars ($4,800).

(C) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(5) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Original rule filed Jan. 4, 2010.

PUBLIC COST: This proposed rule will cost the Missouri Consolidated Health Care Plan and public entities $1,693,097 annually in the aggregate.

PRIVATE COST: This proposed rule will cost private entities

$1,693,097 annually in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 3

Rule Number and Name:	22 CSR 10-3.050 Copay Plan Benefit Provisions and Covered Charges
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003	**$ 1,693,097**

III. WORKSHEET

Estimated cost is the annual cost of 50 percent of the public entity premium for the Copay Plan to all public entity employees who enrolled for coverage under this plan for calendar year 2010.

IV. ASSUMPTIONS

- **Total enrollment under the Copay Plan as of January 1, 2010;**
- **Calendar year 2010 membership in the Copay Plan would remain relatively stable;**
- **Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary;**
- **Calculations are based on Active Employee Only premiums and do not include dependents or retirees;**
- **Calculations are based on average premiums for all entities offering the Copay Plan;**
- **Calculations assume each public entity is contributing at least 50 percent of the premium;**
- **Calculations include pharmacy costs as outlined in 22 CSR 10-3090;**
- **Actual costs will vary based upon actual utilization of services.**

FISCAL NOTE
PRIVATE COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 3

Rule Number and Title:	**22 CSR 10-3.050 Copay Plan Benefit Provisions and Covered Charges**
Type of Rulemaking:	**Proposed Rule**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
561 individuals enrolled in the MCHCP Public Entity Copay Plan for CY 2010	**Individuals enrolled in the MCHCP Public Entity Copay Plan for CY 2010**	**$ 1,693,097**

III. WORKSHEET

Estimated cost is the annual cost of 50 percent of the public entity premium for the Copay Plan to all public entity employees who enrolled for coverage under this plan for calendar year 2010. In addition, members will pay the following copayments based upon their individual utilization of covered benefits under the Copay Plan:

- $25 copayment for a primary care physician office visit
- $35 copayment for a specialist physician office visit or urgent care visit
- $100 copayment for emergency room visit
- $300 copayment for an inpatient hospital admission
- $100 copayment for outpatient surgery

IV. ASSUMPTIONS

- Total enrollment under the Copay Plan as of January 1, 2010;
- Calendar year 2010 membership in the Copay Plan would remain relatively stable;
- Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Calculations are based on Active Employee Only premiums and do not include dependents or retirees;
- Calculations are based on average premiums for all entities offering the Copay Plan;
- Calculations assume each public entity is contributing at least 50 percent of the premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3090;

- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED RULE

22 CSR 10-3.051 PPO 300 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 300 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

(1) Deductible amount—Network: per individual each calendar year, three hundred dollars ($300); family limit each calendar year, six hundred dollars ($600). Non-network: per individual each calendar year, six hundred dollars ($600); family limit each calendar year, one thousand two hundred dollars ($1,200).

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once out-of-pocket maximum is reached.

(A) Network claims—are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims may also be paid at ninety percent (90%) if the subscriber requires covered services that are not available through a network provider within fifty (50) miles of his/her home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network out-of-pocket maximum for individual—one thousand two hundred dollars ($1,200).

(B) Network out-of-pocket maximum for family—two thousand four hundred dollars ($2,400).

(C) Non-network out-of-pocket maximum for individual—two thousand four hundred dollars ($2,400).

(D) Non-network out-of-pocket maximum for family—four thousand eight hundred dollars ($4,800).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(4) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Original rule filed Jan. 4, 2010.

PUBLIC COST: This proposed rule will cost the Missouri Consolidated Health Care Plan and public entities six hundred twenty-six thousand one hundred thirty-one dollars ($626,131) annually in the aggregate.

PRIVATE COST: This proposed rule will cost private entities six hundred twenty-six thousand one hundred thirty-one dollars ($626,131) annually in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 3

Rule Number and Name:	22 CSR 10-3.051 PPO 300 Plan Benefit Provisions and Covered Charges
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003	**$626,131**

III. WORKSHEET

Estimated cost is the annual cost of 50 percent of the public entity premium for the PPO 300 Plan to all public entity employees who enrolled for coverage under this plan for calendar year 2010.

IV. ASSUMPTIONS

- **Total enrollment under the PPO 300 Plan as of January 1, 2010;**
- **Calendar year 2010 membership in the PPO 300 Plan would remain relatively stable;**
- **Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary;**
- **Calculations are based on Active Employee Only premiums and do not include dependents or retirees;**
- **Calculations are based on average premiums for all entities offering the PPO 300 Plan;**
- **Calculations assume each public entity is contributing at least 50 percent of the premium;**
- **Calculations include pharmacy costs as outlined in 22 CSR 10-3090;**
- **Actual costs will vary based upon actual utilization of services.**

FISCAL NOTE
PRIVATE COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 3

Rule Number and Title:	**22 CSR 10-3.051 PPO 300 Plan Benefit Provisions and Covered Charges**
Type of Rulemaking:	**Proposed Rule**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
181 individuals enrolled in the MCHCP Public Entity PPO 300 Plan for CY 2010	**Individuals enrolled in the MCHCP Public Entity PPO 300 Plan for CY 2010**	**$ 626,131**

III. WORKSHEET

Estimated cost is the annual cost of 50 percent of the public entity premium for the PPO 300 Plan to all public entity employees who enrolled for coverage under this plan for calendar year 2010. In addition, members will pay the following copayments based upon their individual utilization of covered benefits under the PPO 300 Plan:

- $300 individual network deductible
- $600 family network deductible
- $600 individual non-network deductible
- $1,200 family non-network deductible
- 10 percent network coinsurance after deductible
- 30 percent non-network coinsurance after deductible
- $1,200 individual network out-of-pocket maximum
- $2,400 family network out-of-pocket maximum
- $2,400 individual non-network out-of-pocket maximum
- $4,800 family non-network out-of-pocket maximum

IV. ASSUMPTIONS

- Total enrollment under the PPO 300 Plan as of January 1, 2010;
- Calendar year 2010 membership in the PPO 300 Plan would remain relatively stable;
- Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Calculations are based on Active Employee Only premiums and do not include dependents or retirees;

- Calculations are based on average premiums for all entities offering the PPO 300 Plan;
- Calculations assume each public entity is contributing at least 50 percent of the premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3090;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED RULE

22 CSR 10-3.052 PPO 500 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 500 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

(1) Deductible amount—Network: per individual each calendar year, five hundred dollars ($500); family limit each calendar year, one thousand five hundred dollars ($1,500). Non-network: per individual each calendar year, one thousand dollars ($1,000); family limit each calendar year, three thousand dollars ($3,000).

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once out-of-pocket maximum is reached.

(A) Network claims—are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims may also be paid at ninety percent (90%) if required covered services are not available through a network provider within fifty (50) miles of the member's home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(3) Copayments—set charges for the following types of claims so long as network providers are utilized.

(A) Office visit—Network: primary care—twenty dollars ($20), specialist—thirty dollars ($30); Non-network: seventy percent (70%) coinsurance after deductible.

(B) Maternity—Network: primary care—twenty dollars ($20) for initial visit, specialist—thirty dollars ($30) for initial visit; Non-network: seventy percent (70%) coinsurance after deductible.

(C) Preventive care—Network: no copayment, covered at one hundred percent (100%); Non-network: seventy percent (70%) coinsurance after deductible.

(D) Emergency room—Network: one hundred dollar ($100) copayment (waived if admitted as inpatient); Non-network: one hundred dollar ($100) copayment (waived if admitted as inpatient).

(E) Urgent care—Network: fifty dollar ($50) copayment; Non-network: fifty dollar ($50) copayment.

(4) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network out-of-pocket maximum for individual—two thousand five hundred dollars ($2,500).

(B) Network out-of-pocket maximum for family—seven thousand five hundred dollars ($7,500).

(C) Non-network out-of-pocket maximum for individual—seven thousand dollars ($7,000).

(D) Non-network out-of-pocket maximum for family—twenty-one thousand dollars ($21,000).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(5) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Original rule filed Jan. 4, 2010.

PUBLIC COST: This proposed rule will cost the Missouri Consolidated Health Care Plan and public entities $1,232,885 annually in the aggregate.

PRIVATE COST: This proposed rule will cost private entities $1,232,885 annually in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 3

Rule Number and Name:	22 CSR 10-3.052 PPO 500 Plan Benefit Provisions and Covered Charges
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003	**$1,232,885**

III. WORKSHEET

Estimated cost is the annual cost of 50 percent of the public entity premium for the PPO 500 Plan to all public entity employees who enrolled for coverage under this plan for calendar year 2010.

IV. ASSUMPTIONS

- **Total enrollment under the PPO 500 Plan as of January 1, 2010;**
- **Calendar year 2010 membership in the PPO 500 Plan would remain relatively stable;**
- **Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary;**
- **Calculations are based on Active Employee Only premiums and do not include dependents or retirees;**
- **Calculations are based on average premiums for all entities offering the PPO 500 Plan;**
- **Calculations assume each public entity is contributing at least 50 percent of the premium;**
- **Calculations include pharmacy costs as outlined in 22 CSR 10-3090;**
- **Actual costs will vary based upon actual utilization of services.**

FISCAL NOTE
PRIVATE COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 3

Rule Number and Title:	**22 CSR 10-3.052 PPO 500 Plan Benefit Provisions and Covered Charges**
Type of Rulemaking:	**Proposed Rule**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
439 individuals enrolled in the MCHCP Public Entity PPO 500 Plan for CY 2010	**Individuals enrolled in the MCHCP Public Entity PPO 500 Plan for CY 2010**	**$ 1,232,885**

III. WORKSHEET

Estimated cost is the annual cost of 50 percent of the public entity premium for the PPO 500 Plan to all public entity employees who enrolled for coverage under this plan for calendar year 2010. In addition, members will pay the following copayments based upon their individual utilization of covered benefits under the PPO 500 Plan:

- $500 individual network deductible
- $1,500 family network deductible
- $1,000 individual non-network deductible
- $3,000 family non-network deductible
- 10 percent network coinsurance after deductible
- 30 percent non-network coinsurance after deductible
- $2,500 individual network out-of-pocket maximum
- $7,500 family network out-of-pocket maximum
- $7,000 individual non-network out-of-pocket maximum
- $21,000 family non-network out-of-pocket maximum
- $20 copayment for a network primary care physician office visit
- $30 copayment for a network specialist physician office visit
- $50 copayment for urgent care visit
- $100 copayment for emergency room visit

IV. ASSUMPTIONS

- Total enrollment under the PPO 500 Plan as of January 1, 2010;
- Calendar year 2010 membership in the PPO 500 Plan would remain relatively stable;

- Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Calculations are based on Active Employee Only premiums and do not include dependents or retirees;
- Calculations are based on average premiums for all entities offering the PPO 500 Plan;
- Calculations assume each public entity is contributing at least 50 percent of the premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3090;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED RULE

22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 1000 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

(1) Deductible amount—Network: per individual each calendar year, one thousand dollars ($1,000); family limit each calendar year, three thousand dollars ($3,000). Non-network: per individual each calendar year, two thousand dollars ($2,000); family limit each calendar year, six thousand dollars ($6,000).

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once out-of-pocket maximum is reached.

(A) Network claims—are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims may also be paid at ninety percent (90%) if required covered services are not available through a network provider within fifty (50) miles of the member's home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(3) Copayments—set charges for the following types of claims so long as network providers are utilized.

(A) Office visit—Network: primary care—twenty dollars ($20), specialist—thirty dollars ($30); Non-network: seventy percent (70%) coinsurance after deductible.

(B) Maternity—Network: primary care—twenty dollars ($20) for initial visit, specialist—thirty dollars ($30) for initial visit; Non-network: seventy percent (70%) coinsurance after deductible.

(C) Preventive care—Network: no copayment, covered at one hundred percent (100%); Non-network: seventy percent (70%) coinsurance after deductible.

(D) Emergency room—Network: one hundred dollar ($100) copayment (waived if admitted as inpatient); Non-network: one hundred dollar ($100) copayment (waived if admitted as inpatient).

(E) Urgent care—Network: fifty dollar ($50) copayment; Non-network: fifty dollar ($50) copayment.

(4) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network out-of-pocket maximum for individual—four thousand five hundred dollars ($4,500).

(B) Network out-of-pocket maximum for family—thirteen thousand five hundred dollars ($13,500).

(C) Non-network out-of-pocket maximum for individual—ten thousand dollars ($10,000).

(D) Non-network out-of-pocket maximum for family—thirty thousand dollars ($30,000).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(5) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Original rule filed Jan. 4, 2010.

PUBLIC COST: This proposed rule will cost the Missouri Consolidated Health Care Plan and public entities two hundred twenty-seven thousand nine hundred thirty-three dollars ($227,933) annually in the aggregate.

PRIVATE COST: This proposed rule will cost private entities two hundred twenty-seven thousand nine hundred thirty-three dollars ($227,933) annually in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. **Department Title: 22 - Missouri Consolidated Health Care Plan**
Division Title: Division 10
Chapter Title: Chapter 3

Rule Number and Name:	22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003	**$227,933**

III. WORKSHEET

Estimated cost is the annual cost of 50 percent of the public entity premium for the PPO 1000 Plan to all public entity employees who enrolled for coverage under this plan for calendar year 2010.

IV. ASSUMPTIONS

- **Total enrollment under the PPO 1000 Plan as of January 1, 2010;**
- **Calendar year 2010 membership in the PPO 1000 Plan would remain relatively stable;**
- **Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary;**
- **Calculations are based on Active Employee Only premiums and do not include dependents or retirees;**
- **Calculations are based on average premiums for all entities offering the PPO 1000 Plan;**
- **Calculations assume each public entity is contributing at least 50 percent of the premium;**
- **Calculations include pharmacy costs as outlined in 22 CSR 10-3090;**
- **Actual costs will vary based upon actual utilization of services.**

FISCAL NOTE
PRIVATE COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 3

Rule Number and Title:	**22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges**
Type of Rulemaking:	**Proposed Rule**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
78 individuals enrolled in the MCHCP Public Entity PPO 1000 Plan for CY 2010	**Individuals enrolled in the MCHCP Public Entity PPO 1000 Plan for CY 2010**	**$ 227,933**

III. WORKSHEET

Estimated cost is the annual cost of 50 percent of the public entity premium for the PPO 1000 Plan to all public entity employees who enrolled for coverage under this plan for calendar year 2010. In addition, members will pay the following copayments based upon their individual utilization of covered benefits under the PPO 1000 Plan:

- $1,000 individual network deductible
- $3,000 family network deductible
- $2,000 individual non-network deductible
- $6,000 family non-network deductible
- 10 percent network coinsurance after deductible
- 30 percent non-network coinsurance after deductible
- $4,500 individual network out-of-pocket maximum
- $13,500 family network out-of-pocket maximum
- $10,000 individual non-network out-of-pocket maximum
- $30,000 family non-network out-of-pocket maximum
- $20 copayment for a network primary care physician office visit
- $30 copayment for a network specialist physician office visit
- $50 copayment for urgent care visit
- $100 copayment for emergency room visit

IV. ASSUMPTIONS

- Total enrollment under the PPO 1000 Plan as of January 1, 2010;

- Calendar year 2010 membership in the PPO 1000 Plan would remain relatively stable;
- Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Calculations are based on Active Employee Only premiums and do not include dependents or retirees;
- Calculations are based on average premiums for all entities offering the PPO 1000 Plan;
- Calculations assume each public entity is contributing at least 50 percent of the premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3090;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED RULE

22 CSR 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 2000 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

(1) Deductible amount—Network: per individual each calendar year, two thousand dollars ($2,000); family limit each calendar year, six thousand dollars ($6,000). Non-network: per individual each calendar year, four thousand dollars ($4,000); family limit each calendar year, twelve thousand dollars ($12,000).

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once out-of-pocket maximum is reached.

(A) Network claims—are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims may also be paid at eighty percent (80%) if required covered services are not available through a network provider within fifty (50) miles of the member's home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(3) Copayments—set charges for the following types of claims so long as network providers are utilized.

(A) Office visit—Network: primary care—twenty-five dollars ($25), specialist—thirty-five dollars ($35); Non-network: sixty percent (60%) coinsurance after deductible.

(B) Maternity—Network: primary care—twenty-five dollars ($25) for initial visit, specialist—thirty-five dollars ($35) for initial visit; Non-network: sixty percent (60%) coinsurance after deductible.

(C) Preventive care—Network: no copayment, covered at one hundred percent (100%); Non-network: sixty percent (60%) coinsurance after deductible.

(D) Emergency room—Network: one hundred dollar ($100) copayment (waived if admitted as inpatient); Non-network: one hundred dollar ($100) copayment (waived if admitted as inpatient).

(E) Urgent care—Network: fifty dollar ($50) copayment; Non-network: fifty dollar ($50) copayment.

(4) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network out-of-pocket maximum for individual—six thousand dollars ($6,000).

(B) Network out-of-pocket maximum for family—eighteen thousand dollars ($18,000).

(C) Non-network out-of-pocket maximum for individual—twelve thousand dollars ($12,000).

(D) Non-network out-of-pocket maximum for family—thirty-six thousand dollars ($36,000).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(5) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Original rule filed Jan. 4, 2010.

PUBLIC COST: This proposed rule will cost the Missouri Consolidated Health Care Plan and public entities nine hundred twenty-three thousand seven hundred sixty-three dollars ($923,763) annually in the aggregate.

PRIVATE COST: This proposed rule will cost private entities nine hundred twenty-three thousand seven hundred sixty-three dollars ($923,763) annually in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 3

Rule Number and Name:	22 CSR 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003	**$923,763**

III. WORKSHEET

Estimated cost is the annual cost of 50 percent of the public entity premium for the PPO 2000 Plan to all public entity employees who enrolled for coverage under this plan for calendar year 2010.

IV. ASSUMPTIONS

- **Total enrollment under the PPO 2000 Plan as of January 1, 2010;**
- **Calendar year 2010 membership in the PPO 2000 Plan would remain relatively stable;**
- **Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary;**
- **Calculations are based on Active Employee Only premiums and do not include dependents or retirees;**
- **Calculations are based on average premiums for all entities offering the PPO 2000 Plan;**
- **Calculations assume each public entity is contributing at least 50 percent of the premium;**
- **Calculations include pharmacy costs as outlined in 22 CSR 10-3090;**
- **Actual costs will vary based upon actual utilization of services.**

FISCAL NOTE
PRIVATE COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 3

Rule Number and Title:	**22 CSR 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges**
Type of Rulemaking:	**Proposed Rule**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
389 individuals enrolled in the MCHCP Public Entity PPO 2000 Plan for CY 2010	**Individuals enrolled in the MCHCP Public Entity PPO 2000 Plan for CY 2010**	**$ 923,763**

III. WORKSHEET

Estimated cost is the annual cost of 50 percent of the public entity premium for the PPO 2000 Plan to all public entity employees who enrolled for coverage under this plan for calendar year 2010. In addition, members will pay the following copayments based upon their individual utilization of covered benefits under the PPO 2000 Plan:

- $2,000 individual network deductible
- $6,000 family network deductible
- $4,000 individual non-network deductible
- $12,000 family non-network deductible
- 20 percent network coinsurance after deductible
- 40 percent non-network coinsurance after deductible
- $6,000 individual network out-of-pocket maximum
- $18,000 family network out-of-pocket maximum
- $12,000 individual non-network out-of-pocket maximum
- $36,000 family non-network out-of-pocket maximum
- $25 copayment for a network primary care physician office visit
- $35 copayment for a network specialist physician office visit
- $50 copayment for urgent care visit
- $100 copayment for emergency room visit

IV. ASSUMPTIONS

- Total enrollment under the PPO 2000 Plan as of January 1, 2010;

- Calendar year 2010 membership in the PPO 2000 Plan would remain relatively stable;
- Calendar year 2010 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Calculations are based on Active Employee Only premiums and do not include dependents or retirees;
- Calculations are based on average premiums for all entities offering the PPO 2000 Plan;
- Calculations assume each public entity is contributing at least 50 percent of the premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3090;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED RULE

22 CSR 10-3.055 High Deductible Health Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the High Deductible Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

(1) Deductible amount—Network: per individual each calendar year, one thousand two hundred dollars ($1,200); family limit each calendar year, two thousand four hundred dollars ($2,400). Non-network: per individual each calendar year, two thousand four hundred dollars ($2,400); family limit each calendar year, four thousand eight hundred dollars ($4,800).

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once out-of-pocket maximum is reached.

(A) Network claims—are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims may also be paid at eighty percent (80%) if required covered services are not available through network provider within fifty (50) miles of the member's home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network out-of-pocket maximum for individual—two thousand four hundred dollars ($2,400).

(B) Network out-of-pocket maximum for family—four thousand eight hundred dollars ($4,800).

(C) Non-network out-of-pocket maximum for individual—four thousand eight hundred dollars ($4,800).

(D) Non-network out-of-pocket maximum for family—nine thousand six hundred dollars ($9,600).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(4) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

(5) Pharmacy benefits are subject to the applicable medical plan deductible and coinsurance.

AUTHORITY: section 103.059, RSMo 2000 and section 103.080.3, RSMo Supp. 2009. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Original rule filed Jan. 4, 2010.

PUBLIC COST: The proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED RULE

22 CSR 10-3.060 PPO 300 Plan, PPO 500 Plan, PPO 1000 Plan, PPO 2000 Plan, HDHP, and Copay Plan Limitations

PURPOSE: This rule establishes the limitations and exclusions of the Missouri Consolidated Health Care Plan PPO 300 Plan, PPO 500 Plan, PPO 1000 Plan, PPO 2000 Plan, HDHP, and/or Copay Plan.

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges or within any of the sections of this rule.

(2) If applicable, all hospitalizations, outpatient treatment for chemical dependency, or mental and nervous disorder that do not receive prior authorization as described in 22 CSR 10-3.045, reimbursement will be reduced by ten percent (10%) of reasonable and customary charges.

(3) Abortion—other than situations where the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.

(4) Allergy services—no coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

(5) Alternative therapies—including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, biofeedback, and other forms of alternative therapy with the exception of aquatic therapy performed by a physical therapist.

(6) Autopsy.

(7) Blood storage, including whole blood, blood plasma, and blood products.

(8) Breast augmentation mammoplasty—not covered unless associated with breast surgery following a medically necessary mastectomy incurred secondary to active disease.

(9) Care received without charge.

(10) Comfort and convenience items.

(11) Cosmetic, plastic, reconstructive, or restorative surgery—unless medically necessary to repair a functional disorder caused by disease, injury, or congenital defect or abnormality (for a participant under the age of nineteen (19)) or to restore symmetry following a mastectomy.

(12) Custodial or domiciliary care—includes services and supplies that assist members in the activities of daily living like walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets and supervision of medication that is usually self-administered.

(13) Dental—treatment must be initiated within sixty (60) days of accident. Limited to treatment of accidental injury to sound natural teeth. Oral surgery is covered only when medically necessary as a direct result from injury, tumors, or cysts. Dental care, including oral surgery, as a result of poor dental hygiene is not covered. Extractions of bony or partial bony impactions are excluded.

(14) Durable medical equipment and disposable supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings, and support hose. Over-the-counter medications and supplies. Prescription compression stockings are limited to two (2) pairs of four (4) individual stockings per plan year.

(15) Educational or psychological testing—not covered unless part of a treatment program for covered services.

(16) Examinations requested by a third party.

(17) Excessive charges—any otherwise eligible expenses that exceed the maximum allowance or benefit limit.

(18) Exercise equipment.

(19) Experimental services or investigational services—experimental or investigational services, procedures, supplies, or drugs as determined by the claims administrator are not covered, except clinical trials for cancer treatment as specified by law.

(20) Eye glasses and contact lenses—charges incurred in connection with the fitting of eye glasses or contact lenses except for initial placement immediately following cataract surgery.

(21) Eye services—health services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

(22) Services obtained at a government facility—not covered if care is provided without charge.

(23) Hair analysis, wigs, and hair transplants—services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also, hairstyling wigs, hairpieces, and hair prostheses, including those ordered by a participating provider, are not covered. Such items and services are not covered except for members ages eighteen (18) and under with alopecia as specified by law. Subject to two hundred dollar ($200) annual maximum and three thousand two hundred dollar ($3,200) lifetime maximum.

(24) Health and athletic club membership—including costs of enrollment.

(25) Immunizations requested by third party or for travel.

(26) Infertility—Infertility treatments are limited to in-vivo (intrauterine, intracervical, intravaginal fertilization). Those health services and associated expenses for the treatment of infertility are not covered, including reversal of voluntary sterilization, intracytoplasmic sperm injection (ICSI), *in vitro* fertilization, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT) procedures; embryo transport; donor sperm and related cost for collection; no cryopreservation of sperm or eggs; and non-medically necessary amniocentesis.

(27) Level of care, if greater than is needed for the treatment of the illness or injury.

(28) Medical care and supplies—not to the extent that they are payable under—

(A) A plan or program operated by a national government or one of its agencies; or

(B) Any state's cash sickness or similar law including any group insurance policy approved under such law.

(29) Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the subscriber, such as a spouse, parent, child, sibling, or brother/sister-in-law.

(30) Military service connected injury or illness.

(31) Non-network providers—subject to deductible and non-network coinsurance.

(32) Not medically necessary services—with the exception of preventive services.

(33) Obesity—medical and surgical intervention is not covered, unless the member meets the definition of severe morbid obesity as defined in 22 CSR 10-3.010 and satisfies all requirements described in the plan. Bariatric surgery will only be covered when prior authorization is received from the medical plan.

(A) Bariatric surgery additional qualifying criteria—

1. Presence of severe morbid obesity that has persisted for at least five (5) years defined as body mass index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions will be considered based on clinical review;

2. Member must be eighteen (18) years of age or older;

3. Documented evidence of at least two (2) failed attempts at weight loss each with a minimum duration of at least six (6) months with the member achieving at least a ten percent (10%) weight loss and meeting the following additional criteria: one (1) attempt must be in a physician-supervised weight loss program and fully documented in the physician's record; the program must use a multidisciplinary approach including dietician consultation, low-calorie diet, increased physical activity, and behavioral modification; nationally recognized program such as Jenny Craig or Weight Watchers (This does not include self-directed low-calorie diets such as the Atkins Diet or South Beach Diet.); and the most recent attempt must have been within the twelve (12)-month period prior to the requested surgery;

4. Documented evidence the member is on a nutrition and exercise program immediately prior to the surgery request;

5. Evidence the member and the attending physician have a lifelong plan for compliance with lifestyle modification requirements;

6. Documentation the member has completed a psychological evaluation and, if appropriate, behavior modification and should be free of major psychiatric diagnosis or a current behavior which would significantly reduce long-term effectiveness of the proposed treatment; and

7. Procedure must be performed at a Centers of Excellence (COE) facility for Bariatric Surgery as determined by the Centers for Medicare and Medicaid Services.

(B) Network services are limited to one (1) operative procedure for the treatment of obesity per lifetime. Non-network obesity services are not covered.

(C) Revisions and corrections of bariatric procedures only when the revision is used to treat life-threatening complications (e.g. wound infection, abscess, dehiscence, gastric leaking, and embolism). Coverage is limited to the following bariatric procedures: Roux-en-Y Gastric Bypass—open and laparoscopic (RYGBP), Laparoscopic Adjustable Gastric Banding (LAGB), and Open and Laparoscopic Biliopancreatic Diversion with Duodenal Switch (BPD/DS).

(34) Orthognathic surgery.

(35) Orthoptics.

(36) Other charges—no coverage for charges that would not be incurred if the subscriber was not covered. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan. Miscellaneous service charges—telephone consultations, charges for failure to keep scheduled appointment (unless the scheduled appointment was for a mental health service), or any late payment charge.

(37) Over-the-counter medications—except for insulin through the pharmacy benefit.

(38) Over-the-counter supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings, and support hose.

(39) Physical fitness.

(40) Physical, speech, and occupational therapy—health services and associated expenses for development delay. Treatment for disorders relating to delays in learning, motor skills, and communications.

(41) Private duty nursing.

(42) Prosthetic repair or replacement—not covered unless due to normal wear and tear, if there is a change in medical condition, if growth related, or medically necessary.

(43) Services not specifically included as benefits.

(44) Services rendered after termination of coverage—those services otherwise covered under the agreement, but rendered after the date coverage under the agreement terminates, including services for medical conditions arising prior to the date individual coverage under the agreement terminates.

(45) Stimulators (for bone growth)—not covered unless authorized by claims administrator.

(46) Surrogacy—pregnancy coverage is limited to plan member.

(47) Temporo-Mandibular Joint Syndrome (TMJ).

(48) Third-party examinations.

(49) Tobacco cessation—patches and gum are not covered. There is a limited benefit available under the pharmacy benefit.

(50) Transplants—double listing—payment only for one (1) evaluation up to time of actual transplant.

(51) Transplants—travel expense—requires authorization from medical plan. Limited to ten thousand dollar ($10,000) maximum per transplant when accessing network services.

(52) Transsexual surgery—health services and associated expenses in the transformation operations regardless of any diagnosis or gender role disorientation or psychosexual orientation or any treatment or studies related to sex transformation. Also excludes hormonal support for sex transformation.

(53) Travel expenses—not covered unless authorized by claims administrator.

(54) Trimming of nails, corns, or calluses—not covered except for persons being treated for diabetes, peripheral vascular disease, or blindness.

(55) Usual, Customary, and Reasonable (UCR)—charges exceeding UCR are not covered, as applicable to the non-network benefit.

(56) Vitamins and nutrients—limited to prenatal agents for pregnancy, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents through the pharmacy benefit.

(57) War or insurrection—liability to provide services limited in the event of a major disaster, epidemic, riot, or other circumstances beyond the control of the plan.

(58) Workers' compensation—charges for services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other legislation of similar program.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Original rule filed Jan. 4, 2010.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED RULE

22 CSR 10-3.090 Pharmacy Benefit Summary

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Pharmacy Benefit Summary for Copay Plan, PPO 300 Plan, PPO 500 Plan, PPO 1000 Plan, and PPO 2000 Plan of the Missouri Consolidated Health Care Plan.

(1) The pharmacy benefit provides coverage for prescription drugs, as described in the following:

(A) Medications.

1. Network:

A. Generic: Eight dollar ($8) copayment for up to a thirty (30)-day supply for generic drug on the formulary;

B. Formulary brand: Thirty-five dollar ($35) copayment for up to a thirty (30)-day supply for brand drug on the formulary;

C. Non-formulary: Fifty-five dollar ($55) copayment for up to a thirty (30)-day supply for non-formulary drug;

D. Prescriptions filled with a formulary brand drug when there is a Food and Drug Administration (FDA)-approved generic will be subject to the generic copayment amount in addition to paying the difference between the cost of the generic and the formulary brand drug;

E. Mail order program—

(I) Prescriptions may be filled through the mail order program and the member will receive up to a ninety (90)-day supply for two and one-half (2 ½) regular copayments.

(II) Specialty drugs covered only through network mail order for up to thirty (30) days. Copayments:

(a) Generic: six dollars and sixty-seven cents ($6.67);

(b) Formulary brand: twenty-nine dollars and seventeen cents ($29.17); and

(c) Non-formulary: forty-five dollars and eighty-three cents ($45.83).

2. Non-network pharmacies—If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable copayment. All such claims must be filed within twelve (12) months of the incurred expense.

3. Retail prescription drugs—Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.

(2) If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug rather than the copayment.

(3) Retail and mail order coverage includes the following (except for specialty drugs):

(A) Diabetic supplies, including:

1. Insulin;
2. Syringes;
3. Test strips;
4. Lancets; and
5. Glucometers;

(B) Prescribed vitamins, excluding those vitamins that may be purchased over-the-counter;

(C) Prescribed self-injectables;

(D) Oral chemotherapy agents;

(E) Hematopoietic stimulants;

(F) Growth hormones with prior authorization;

(G) Infertility drugs—subject to fifty percent (50%) member coinsurance; and

(H) Tobacco cessation prescriptions—subject to formulary restrictions and limited to five hundred dollar ($500) annual benefit.

(4) Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. This program involves the member's physician and is only for members who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a first step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first step drug, the physician may request a prior authorization from the pharmacy plan administrator. If the prior authorization is approved, the member is responsible for the applicable copayment which may be higher than the first step drug. If the requested prior authorization is not approved, then the member is responsible for the full price of the drug.

(A) First Step—

1. Uses primarily generic drugs;
2. Lowest applicable copayment is charged; and
3. First step drugs must be used before the plan will authorize payment for second step drugs.

(B) Second Step—

1. This step applies if the member's treatment plan requires a different medication after attempting the first step medication;
2. Uses primarily brand-name drugs; and
3. Typically, a higher copayment amount is applicable.

(5) Prior Authorization—Certain medications are subject to prior authorization. Network pharmacies will notify the member if prior authorization is required. The member or the pharmacy must contact the pharmacy plan administrator before payment will be approved.

(6) Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. Members may request claim forms from the plan or the pharmacy plan administrator. In order to file a claim, members must—

(A) Complete the claim form; and

(B) Attach a prescription receipt or label with the claim form. Patient history printouts from the pharmacy are acceptable but must be signed by the pharmacist. Cash register receipts are not acceptable for any prescriptions, except diabetic supplies. If attaching a receipt or label, the receipt or label shall include—

1. Pharmacy name and address;
2. Patient's name;
3. Price;
4. Date filled;
5. Drug name, strength, and national drug code (NDC);
6. Prescription number;
7. Quantity; and
8. Days supply.

(7) Formulary—The formulary does not change during a calendar year, unless—

(A) A generic drug becomes available to replace the brand-name drug. If this occurs, the generic copayment applies; or

(B) A drug becomes available over-the-counter. If this occurs, then the drug is no longer covered under the pharmacy benefit; and

(C) A drug is determined to have a safety issue.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. Original rule filed Jan. 4, 2010.

PUBLIC COST: The proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Richard Bowles, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

This section will contain the final text of the rules proposed by agencies. The order of rulemaking is required to contain a citation to the legal authority upon which the order of rulemaking is based; reference to the date and page or pages where the notice of proposed rulemaking was published in the *Missouri Register*; an explanation of any change between the text of the rule as contained in the notice of proposed rulemaking and the text of the rule as finally adopted, together with the reason for any such change; and the full text of any section or subsection of the rule as adopted which has been changed from that contained in the notice of proposed rulemaking. The effective date of the rule shall be not less than thirty (30) days after the date of publication of the revision to the *Code of State Regulations*.

The agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments which are opposed in whole or in part to the proposed rule. The ninety (90)-day period during which an agency shall file its order of rulemaking for publication in the *Missouri Register* begins either: 1) after the hearing on the proposed rulemaking is held; or 2) at the end of the time for submission of comments to the agency. During this period, the agency shall file with the secretary of state the order of rulemaking, either putting the proposed rule into effect, with or without further changes, or withdrawing the proposed rule.

Title 9—DEPARTMENT OF MENTAL HEALTH
Division 30—Certification Standards
Chapter 4—Mental Health Programs

ORDER OF RULEMAKING

By the authority vested in the Director of the Department of Mental Health under section 630.050, RSMo Supp. 2009 and sections 630.655 and 632.050, RSMo 2000, the rule is adopted as follows:

9 CSR 30-4.0432 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on September 15, 2009 (34 MoReg 1986–1990). Those sections with changes are reprinted here. This proposed rule becomes effective thirty days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The department received sixteen (16) comments on the proposed rule.

COMMENT #1: Two (2) comments were received stating that a paraprofessional mental health worker should be added as a multidisciplinary Assertive Community Treatment (ACT) team member under section (5). The paraprofessional may have a bachelor's degree in a field other than behavioral sciences or a high school diploma and work experience with adults with severe and persistent mental illness or with individuals with similar human services' needs. The comments include a recommendation that the paraprofessional should participate in assessment, treatment planning, and service delivery activities but not assume case management responsibilities.
RESPONSE: The department has not revised the rule as requested because the current proposed rule permits the desired request in subsection (5)(I).

COMMENT #2: Two (2) individuals stated that both a licensed practical nurse and a registered nurse should qualify under subsection (5)(C). The commenter recommended that the licensed practical nurse should have several years of experience working with persons with mental illness.
RESPONSE: The department disagrees with this comment and has not revised the rule as requested because a registered nurse is needed to fulfill all the necessary functions of the multidisciplinary team nurse.

COMMENT #3: Two (2) individuals recommended that a program assistant should not be assigned to the team as a team member in subsection (5)(H) because this is an unreasonable expectation in a large agency with multiple services. It was suggested that the non-clinical team support functions be addressed as stated in section (6) or section (12).
RESPONSE AND EXPLANATION OF CHANGE: The department is in partial agreement with this comment and has revised the rule accordingly by maintaining the requirement for a program assistant but allowing for a prorated Full-Time Equivalent (FTE) depending on team size.

COMMENT #4: A comment was received regarding subsection (7)(E) recommending that NOS (not otherwise specified) not be included as a qualifying diagnosis. The commenter stated that this diagnosis does not necessarily indicate a long-term psychiatric disability and that clients in this program should have established contacts with mental health services.
RESPONSE: The department disagrees with this comment and has not revised the rule as requested because the rule states that additional admission criteria must also be met.

COMMENT #5: One (1) commenter recommended that the initial assessment described in subsection (8)(G) should not be completed on the day of admission but no later than the third session so as not to create delays in services.
RESPONSE: The department disagrees with this comment and has not revised the rule as requested.

COMMENT #6: A similar comment was made regarding subsection (8)(H) about the initial treatment plan. The comment recommends that the time period to complete the initial treatment plan should be increased to no later than the third session.
RESPONSE: The department disagrees with this comment and has not revised the rule as requested.

COMMENT #7: One (1) comment was received recommending that, in subsection (9)(F), the comprehensive assessment should be updated annually.
RESPONSE: The department disagrees with this comment and has not revised the rule as requested.

COMMENT #8: In subsection (9)(F), one (1) commenter recommended that the comprehensive assessment not be completed on the day of admission but that a provisional triage-based service plan be created to initiate care and establish some immediate collaborative goals.
RESPONSE: The department disagrees with this comment and has not revised the rule as requested because a comprehensive assessment is not required on the day of admission. The initial assessment shall be completed on the day of admission as stated in subsection (8)(G) which functions as a provisional triage-based plan to initiate care and establish some immediate collaborative goals.

COMMENT #9: An individual commented that in subsection (9)(L), treatment plans should not be rewritten every six (6) months and recommends instead to require that a note describing the review and update of the treatment plan should suffice.
RESPONSE: The department disagrees with this comment and has not revised the rule as requested because the rule does not require that the treatment plan be rewritten to assure a means for review.

COMMENT #10: Two (2) individuals commented that, in subsection (9)(L), treatment plans should be reviewed quarterly.
RESPONSE: The department disagrees with this comment and has not revised the rule as requested because agencies may choose to review treatment plans more often than required in this rule.

COMMENT #11: In subsection (10)(E), the commenter stated that it is ill advised to expect no more than ten percent (10%) of individuals to graduate annually because more individuals may be prepared for discharge in a given year. The commenter recommends that the discharge criteria listed in a subsequent subsection of this rule be applied and to delete this percentage as a requirement.
RESPONSE AND EXPLANATION OF CHANGE: The department agrees with this comment and has revised the rule as requested to clarify the difference between graduating and dropping out of the program.

COMMENT #12: A comment was received on subsection (10)(I) indicating that the clinical staff-to-client ratio should be 10:1.
RESPONSE: The department disagrees with this comment and has not revised the rule as requested because the standard applies as long as the team continues to demonstrate acceptable outcomes.

COMMENT #13: A comment was received regarding subsection (10)(M). The commenter recommended that all clients should not be seen multiple times daily unless indicated. The recommendation included changing the language to reference those clients with severe, emergent, or acute symptoms.
RESPONSE AND EXPLANATION OF CHANGE: The department agrees with this comment and has revised the rule as requested.

COMMENT #14: Two (2) commenters recommended that clients should have, on average, contact with more than two (2) team members per month or contact with at least two (2) team members per month in subsection (10)(O) providing more flexibility.
RESPONSE: The department disagrees with this comment and has not revised the rule as requested.

COMMENT #15: A comment was received regarding subsection (10)(P) recommending elimination of this requirement or amending the requirement to one (1) or two (2) contacts per week including informal integrated dual disorder treatment; or indicate that these clients need to have their substance abuse issues addressed appropriately in the treatment plan to include weekly interventions including informal integrated dual disorder treatment.
RESPONSE AND EXPLANATION OF CHANGE: The department agrees with this comment and has revised the rule as requested.

COMMENT #16: Regarding subsection (10)(T), the commenter recommends this requirement be rewritten to indicate that for at least ninety percent (90%) of clients, natural support system contacted by the team at least two (2) times per month.
RESPONSE: The department disagrees with this comment and has not revised the rule as requested.

9 CSR 30-4.0432 Assertive Community Treatment Programs

(5) Personnel and Staff Development. ACT shall be delivered by a multidisciplinary team (team) responsible for coordinating a comprehensive array of services. The team shall include, but is not limited to, the following disciplines:

(H) The team shall include a program assistant. A team of one hundred (100) individuals requires one (1) Full-Time Equivalent (FTE) prorated based on team size. The program assistant shall have education and experience in human services or office management. The program assistant shall organize, coordinate, and monitor all non-clinical operations of the team including, but not limited to, the following:

1. Managing medical records;
2. Operating and coordinating the management information system; and
3. Triaging telephone calls and coordinating communication between the team and individuals receiving ACT services.

(10) Service Provision.

(E) Individuals are offered services on a time unlimited basis, with less than ten percent (10%) dropping out annually, excluding those who graduate from services.

(M) Individuals who are experiencing severe, emergent, or acute symptoms shall be contacted multiple times daily by the team.

(P) Individuals with co-occurring substance abuse disorders shall be provided integrated mental health and substance abuse treatment.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 15—Hospital Program

ORDER OF RULEMAKING

By the authority vested in the MO HealthNet Division under sections 208.152, 208.153, 208.201, and 208.471, RSMo Supp. 2009, the division amends a rule as follows:

13 CSR 70-15.010 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on September 1, 2009 (34 MoReg 1802–1805). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Social Services, MO HealthNet Division, received and reviewed written comments on the proposed amendment from eleven (11) sources: The Missouri Hospital Association; HCA Midwest Health System; Saint Louis University Hospital; Royal Oaks Hospital; Ranken Jordan Pediatric Specialty Hospital; CenterPointe Hospital; Lashly & Baer, P.C.; the Honorable Jeanette Mott Oxford, representing the 59th District in the Missouri House of Representatives; the Honorable Jim Lembke, representing the 1st District in the Missouri Senate; the Honorable Rachel Storch, representing the 64th District in the Missouri House of Representatives; and the Honorable Barney Fisher, representing the 125th District in the Missouri House of Representatives. The comments are summarized as follows:

COMMENT #1: Several commenters described the potential reductions in MO HealthNet payments to hospitals as a result of the proposed changes to the better of days and utilization adjustment calculations as too abrupt, severe, rapid, and drastic, and commented that the potential reduction in Medicaid payments "in such a sudden and significant manner" would adversely impact their hospitals. Most commenters suggested that the proposed amendment include a transition or phase-in period for reductions in estimated days and utilization adjustments used to determine Direct Medicaid payments, so that hospitals could adjust over time to potential reductions in Medicaid reimbursement.

RESPONSE AND EXPLANATION OF CHANGE: The MO HealthNet Division (MHD) has been discussing the need to revise the use of the "better of" estimated Medicaid patient days and the utilization adjustment with the hospital industry since August 2008 so they were aware of the change. MHD has taken the comments into consideration and has revised the proposed amendment in the final order of rulemaking to reduce the initial impact on hospitals and allow for a longer transition period. Subsection (15)(B) of the proposed amendment will be changed to phase out the use of the better of days as follows: if the estimated MO HealthNet patient days used in the prior state fiscal year are greater than the current state fiscal year's estimated days, the estimated MO HealthNet patient days used in the prior state fiscal year will be reduced by twenty-five percent (25%) of the difference effective January 1, 2010, fifty percent (50%) of the difference effective July 1, 2010, seventy-five percent (75%) of the difference effective July 1, 2011, and estimated days for the current state fiscal year shall be used effective July 1, 2012, forward. Subsection (15)(B) of the proposed amendment will also be changed to phase out the utilization adjustment for hospitals as follows: Hospitals other than safety net hospitals, children's hospitals, and specialty pediatric hospitals shall receive sixty-seven percent (67%) of the utilization adjustment effective January 1, 2010, thirty-four percent (34%) effective July 1, 2010, and no utilization adjustment shall apply effective July 1, 2011, forward; children's hospitals and specialty pediatric hospitals shall receive sixty-seven percent (67%) of the utilization adjustment effective January 1, 2010, and fifty percent (50%) effective July 1, 2010, forward. Safety net hospitals shall continue to receive one hundred percent (100%) of the utilization adjustment.

COMMENT #2: Several commenters suggested that the proposed amendment include caps, limitations, or stop-losses on reductions in Medicaid payment reductions that may occur as a result of the proposed amendment. Several commenters indicated that subparagraph (15)(B)4.A. of the proposed amendment eliminates the utilization adjustment for most hospitals but allows children's hospitals to continue receiving fifty percent (50%) of their utilization adjustments. The commenters cited this provision as an example of a stop-loss already incorporated in the proposed amendment. They commented further on their recommendation of a stop-loss provision in the proposed amendment by citing the three (3)-percentage-point change limitation in the annual calculation of outpatient prospective payment rates as an example of an existing stop-loss provision in the current regulation.
RESPONSE: MHD believes it has addressed the commenters' concerns regarding caps and limitations in the response and explanation of change for the previous comment. MHD believes that the revisions to the proposed amendment will treat all facilities in an equitable manner. MHD would point out that the three (3)-percentage-point limitation for outpatient rate calculation is not a provision in a rule but is part of the regression calculation used to set a hospital's prospective outpatient percentage. No change to the rule text was made as a result of this comment.

COMMENT #3: Two (2) commenters indicated that the department's intent is unclear regarding the application of subparagraph (15)(B)4.A. of the proposed amendment to Ranken Jordan Pediatric Specialty Hospital. The commenters stated that Ranken Jordan met the definition of a children's hospital and noted in their comments that payment projections for state fiscal year 2010 showed that Ranken Jordan did not receive the fifty percent (50%) utilization adjustment afforded children's hospitals under the proposed amendment. They recommended in their comments that subparagraph (15)(B)4.A. of the proposed amendment be revised to include specialty pediatric hospitals with children's hospitals as hospitals qualifying for fifty percent (50%) of their utilization adjustments.
RESPONSE AND EXPLANATION OF CHANGE: MHD has taken these comments into consideration and has revised the proposed amendment in the final order of rulemaking to treat the utilization adjustment for specialty pediatric hospitals in the same manner as the children's hospitals. MHD would point out that Ranken Jordan does not meet the definition of a children's hospital as noted in the comments. It is defined as a specialty pediatric hospital, which is not the same as a children's hospital. MHD is not going to revise the definition of a children's hospital in subsection (2)(S) of the rule to include specialty pediatric hospitals. However, MHD has revised subparagraph (15)(B)4.A. of the proposed amendment to treat the utilization adjustment for specialty pediatric hospitals in the same manner as the children's hospitals (detailed above in the division's response and explanation of change to the first comment).

COMMENT #4: Several commenters indicated that while the Federal Reimbursement Allowance (FRA) tax assessment increased from $845 million in state fiscal year (SFY) 2009 to $880 million in SFY 2010, MHD was proposing a rule to potentially reduce Medicaid payments to hospitals beginning in SFY 2010. They questioned why the FRA assessment was increasing in SFY 2010 when the proposed rule contained no additional Medicaid payments. They commented that the proposed amendment would have a negative financial impact, yet the proposed amendment's fiscal note indicates the "amendment will not cost private entities more than five hundred dollars ($500) in the aggregate." Another commenter questioned if the proposed cost of the amendment to private entities would be limited to five hundred dollars ($500).
RESPONSE AND EXPLANATION OF CHANGE: MHD disputes the assumption in this comment that MO HealthNet payments to Missouri hospitals will decrease in SFY 2010 while the hospitals' FRA tax assessment will increase in SFY 2010. MHD payments to Missouri hospitals in SFY 2010, in the aggregate, were projected to increase by approximately $23 million over SFY 2009 payments. The SFY 2010 payments and assessments are based on the most current hospital cost report data and applied trend factors. No change to the rule text was made as a result of this comment. A revised fiscal note, however, will be included with the order of rulemaking.

COMMENT #5: Several commenters indicated that the better of days calculations and the utilization adjustments being revised in the proposed amendment have been approved by the Centers for Medicare and Medicaid Services (CMS). The commenters also noted that the better of days calculation methodology has only been incorporated as part of the regulation since January 30, 2009, and questioned why MHD is changing a provision that was codified only months ago.
RESPONSE: The State Plan approved by CMS allows MHD to use estimated Medicaid patient days to calculate prospective payments to hospitals. The estimate is more specifically defined in the rule. The "better of days" provision in paragraph (15)(B)2. of the rule was recently added to clarify the method of estimating patient days and is being redefined in this regulation. MHD constantly strives to pay hospitals appropriately for Medicaid days served. As MHD compared actual days to estimated days, it became apparent that the estimate methodology resulted in an inflated estimate. MHD will continue to define and redefine methodologies for calculating estimates so that estimates closely reflect actual experience. No change to the rule text was made as a result of this comment.

COMMENT #6: Several commenters indicated that two (2) St. Louis area hospitals may close if the proposed amendment is implemented; that MO HealthNet participants would utilize other St. Louis hospitals with higher patient costs if the two (2) lower-cost hospitals close; and that this shift in utilization to higher-cost hospitals would result in higher MO HealthNet hospital payments and exceed any potential Medicaid savings from the proposed amendment.
RESPONSE: For over a year, MHD has reviewed its methodology for estimating Medicaid patient days for hospital Direct Medicaid payments and has continuously shared its findings with the hospital industry. The most notable finding was the excess Medicaid patient

days estimated for some Missouri hospitals as a result of the "better of days" provision. In cases where hospitals merge, change service mix, and close specialized units, the "better of days" calculation results in estimated Medicaid days that are much higher than actual experience. The two (2) St. Louis area hospitals at the heart of this comment have a significant variance between estimated days and actual Medicaid patient days because of changes in the services provided by each hospital.

The comment assumes that MO HealthNet participants will be forced to choose a higher-cost hospital if the two (2) St. Louis hospitals close. Some of the commenters have identified three (3) particular St. Louis area hospitals as the only alternatives for patients who would otherwise be admitted to the two (2) hospitals in question. The information to make such determinations is not readily identifiable or quantifiable as this is an assumed scenario that has not actually occurred. There are twenty-three (23) hospitals within St. Louis city and county that will provide alternatives for care for Medicaid patients. Some migration of patients from the two (2) hospitals has already occurred as a result of curtailed services at one (1) of the hospitals. Statewide the regulation resulted in a net Medicaid savings. The savings provided the state match enabling MHD to continue to make hospital Direct Medicaid payments. No change to the rule text was made as a result of this comment.

COMMENT #7: One (1) commenter indicated that if a particular St. Louis area hospital is forced to close as a result of reduced Medicaid reimbursement from the proposed amendment, the additional Medicaid days for certain other St. Louis hospitals would increase, causing future increases in graduate medical education (GME) payments. The comment included an estimate of $9 million in additional Medicaid GME payments as a result of Medicaid patient days migrating from the "closed" hospital to three (3) area hospitals.
RESPONSE: The commenter's assumption is similar to that in the previous comment—that if a particular St. Louis area hospital were to close, MO HealthNet participants would be admitted to one (1) of three (3) other St. Louis area hospitals that report GME costs. Again, MHD questions the assumption that the MHD participants would go to only those three (3) other hospitals. No change to the rule text was made as a result of this comment.

COMMENT #8: One (1) commenter indicated that if the proposed amendment forces two (2) particular St. Louis area hospitals to close, the state would lose an estimated $10.1 million per year in FRA hospital provider tax revenues from the closed hospitals.
RESPONSE: When patients migrate to other hospitals, it results in an increase in revenues to those hospitals serving the patients. Any lost FRA assessment revenue from a hospital closing is likely to be reported as revenue by other area hospitals. Also, the FRA provider tax assessment is based on the amount needed to make estimated hospital payments as defined in statute and regulations. The aggregate need would be compensated by adjusting the assessment or tax rate applied to all hospitals. No change to the rule text was made as a result of this comment.

13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology

(15) Direct Medicaid Payments.

(B) Direct Medicaid payment will be computed as follows:

1. The MO HealthNet share of the inpatient FRA assessment will be calculated by dividing the hospital's inpatient Medicaid patient days by the total inpatient hospital patient days from the hospital's base cost report to arrive at the inpatient Medicaid utilization percentage. This percentage is then multiplied by the inpatient FRA assessment for the current SFY to arrive at the increased allowable MO HealthNet costs for the inpatient FRA assessment. The MO HealthNet share of the outpatient FRA assessment will be calculated by dividing the hospital's outpatient MO HealthNet charges by the total outpatient hospital charges from the base cost report to arrive at the MO HealthNet utilization percentage. This percentage is then multiplied by the outpatient FRA assessment for the current SFY to arrive at the increased allowable MO HealthNet costs for the outpatient FRA assessment;

2. The unreimbursed MO HealthNet costs are determined by subtracting the hospital's per diem rate from its trended per diem costs. The difference is multiplied by the estimated MO HealthNet patient days for the current SFY plus the out-of-state days from the fourth prior year cost report trended to the current SFY. The estimated MO HealthNet patient days for the current SFY shall be the better of the sum of the Fee-for-Service (FFS) days plus managed care days or the days used in the prior SFY's Direct Medicaid payment calculation. The FFS days are determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior SFY. The managed care days are based on the FFS days determined from the regression analysis, as follows: The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report. The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

A. Effective January 1, 2010, the estimated MO HealthNet patient days shall be the better of the sum of the FFS days plus managed care days or the days used in the prior SFY's Direct Medicaid payment calculation (i.e., for SFY 2010, prior SFY would be SFY 2009) adjusted downward by twenty-five percent (25%) of the difference between the sum of the FFS days plus managed care days and the days used in the prior SFY's Direct Medicaid payment calculation.

(I) The FFS days plus managed care days are determined as follows: The FFS days are determined by applying a trend to the second prior Calendar Year (CY) days (i.e., for SFY 2010, second prior CY would be 2008) as determined from the state's Medicaid Management Information System (MMIS). The trend is determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior CY. The managed care days are based on the FFS days determined from the regression analysis, as follows: The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report. The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

(II) The days used in the prior SFY's Direct Medicaid payment calculation adjusted downward by twenty-five percent (25%) are determined as follows: The days used in the prior SFY's Direct Medicaid payment calculation are compared to the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I). If the hospital has greater estimated days as used in the prior SFY's Direct Medicaid payment calculation than the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I), the difference between the days is multiplied by twenty-five percent (25%) and this amount is removed from the estimated days used in the prior SFY's Direct Medicaid payment calculation to arrive at the current year's estimated days.

B. Effective July 1, 2010, the estimated MO HealthNet patient days shall be the better of the sum of the FFS days plus managed care days or the days used in the SFY 2009 Direct Medicaid payment calculation adjusted downward by fifty percent (50%) of the difference between the sum of the FFS days plus managed care days and the days used in the SFY 2009 Direct Medicaid payment calculation.

(I) The FFS days plus managed care days are determined as set forth in part (15)(B)2.A.(I).

(II) The days used in the prior SFY's Direct Medicaid payment calculation adjusted downward by fifty percent (50%) are determined as follows: The days used in the prior SFY's Direct Medicaid payment calculation are compared to the sum of the FFS days plus

managed care days as determined in part (15)(B)2.A.(I). If the hospital has greater estimated days as used in the prior SFY's Direct Medicaid payment calculation than the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I), the difference between the days is multiplied by fifty percent (50%) and this amount is removed from the estimated days used in the prior SFY's Direct Medicaid payment calculation to arrive at the current year's estimated days.

C. Effective July 1, 2011, the estimated MO HealthNet patient days shall be the better of the sum of the FFS days plus managed care days or the days used in the SFY 2009 Direct Medicaid payment calculation adjusted downward by seventy-five percent (75%) of the difference between the sum of the FFS days plus managed care days and the days used in the SFY 2009 Direct Medicaid payment calculation.

(I) The FFS days plus managed care days are determined as set forth in part (15)(B)2.A.(I).

(II) The days used in the prior SFY's Direct Medicaid payment calculation adjusted downward by seventy-five percent (75%) are determined as follows: The days used in the prior SFY's Direct Medicaid payment calculation are compared to the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I). If the hospital has greater estimated days as used in the prior SFY's Direct Medicaid payment calculation than the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I), the difference between the days is multiplied by seventy-five percent (75%) and this amount is removed from the estimated days used in the prior SFY's Direct Medicaid payment calculation to arrive at the current year's estimated days.

D. Effective July 1, 2012, the estimated MO HealthNet patient days shall be the sum of the FFS days plus managed care days. The FFS days plus managed care days are determined as set forth in part (15)(B)2.A.(I).

E. The trended cost per day is calculated by trending the base year costs per day by the trend indices listed in paragraph (3)(B)1., using the rate calculation in subsection (3)(A). In addition to the trend indices applied to inflate base period costs to the current fiscal year, base year costs will be further adjusted by a Missouri Specific Trend. The Missouri Specific Trend will be used to address the fact that costs for Missouri inpatient care of MO HealthNet residents have historically exceeded the compounded inflation rates estimated using national hospital indices for a significant number of hospitals. The Missouri Specific Trend will be applied at one and one-half percent (1.5%) per year to the hospital's base year. For example, hospitals with a 1998 base year will receive an additional six percent (6%) trend, and hospitals with a 1999 base year will receive an additional four and one-half percent (4.5%) trend.

F. For hospitals that meet the requirements in paragraphs (6)(A)1., (6)(A)2., and (6)(A)4. of this rule (safety net hospitals), the base year cost report may be from the third prior year, the fourth prior year, or the fifth prior year. For hospitals that meet the requirements in paragraphs (6)(A)1. and (6)(A)3. of this rule (first tier Disproportionate Share Hospitals), the base year operating costs may be the third or fourth prior year cost report. The MO HealthNet Division shall exercise its sole discretion as to which report is most representative of costs. For all other hospitals, the base year operating costs are based on the fourth prior year cost report. For any hospital that has both a twelve (12)-month cost report and a partial year cost report, its base period cost report for that year will be the twelve (12)-month cost report.

G. The trended cost per day does not include the costs associated with the FRA assessment, the application of minimum utilization, the utilization adjustment, and the poison control costs computed in paragraphs (15)(B)1., 3., 4., and 5.;

3. The minimum utilization costs for capital and medical education is calculated by determining the difference in the hospital's cost per day when applying the minimum utilization as identified in paragraph (5)(C)4., and without applying the minimum utilization. The difference in the cost per day is multiplied by the estimated MO HealthNet patient days for the SFY;

4. The utilization adjustment cost is determined by estimating the number of MO HealthNet inpatient days the hospital will not provide as a result of the managed care health plans limiting inpatient hospital services. These days are multiplied by the hospital's cost per day to determine the total cost associated with these days. This cost is divided by the remaining total patient days from its base period cost report to arrive at the increased cost per day. This increased cost per day is multiplied by the estimated MO HealthNet days for the current SFY to arrive at the MO HealthNet utilization adjustment.

A. Effective January 1, 2010, hospitals other than safety net hospitals as defined in subsection (6)(B) will receive sixty-seven percent (67%) of the utilization adjustment calculated in accordance with paragraph (15)(B)4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph (15)(B)4.

B. Effective July 1, 2010, hospitals other than safety net hospitals as defined in subsection (6)(B), children's hospitals as defined in subsection (2)(S), and specialty pediatric hospitals as defined in subsection (2)(P) will receive thirty-four percent (34%) of the utilization adjustment calculated in accordance with paragraph (15)(B)4. Children's hospitals and specialty pediatric hospitals will receive fifty percent (50%) of the adjustment calculated in accordance with paragraph (15)(B)4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph (15)(B)4.

C. Effective July 1, 2011, the utilization adjustment will no longer apply to any hospital other than safety net hospitals as defined in subsection (6)(B), children's hospitals as defined in subsection (2)(S), and specialty pediatric hospitals as defined in subsection (2)(P). Children's hospitals and specialty pediatric hospitals will continue to receive fifty percent (50%) of the adjustment calculated in accordance with paragraph (15)(B)4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph (15)(B)4.

5. The poison control cost shall reimburse the hospital for the prorated MO HealthNet managed care cost. It will be calculated by multiplying the estimated MO HealthNet share of the poison control costs by the percentage of managed care participants to total MO HealthNet participants; and

6. Prior to July 1, 2006, the costs for including out-of-state Medicaid days is calculated by subtracting the hospital's per diem rate from its trended per diem cost and multiplying this difference by the out-of-state Medicaid days from the base year cost report. Effective July 1, 2006, the costs for including out-of-state Medicaid days is calculated by subtracting the hospital's per diem rate from its trended per diem cost and multiplying this difference by the out-of-state Medicaid days as determined from the regression analysis performed using the out-of-state days from the fourth, fifth, and sixth prior year cost reports.

REVISED PUBLIC COST: This amendment will result in additional MO HealthNet payments to private entities of approximately $38,982,240 for SFY 2010 over the original estimated increase of $22,911,742.

REVISED FISCAL NOTE
PUBLIC COST

I. Department Title: Department of Social Services
Division Title: MO HealthNet Division
Chapter Title: Hospital Program

Rule Number and Name:	13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology
Type of Rulemaking:	Final Order of Rulemaking

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
MO HealthNet Division	**SFY 2010 = $38,982,240**

III. WORKSHEET

Description	SFY 2009	SFY 2010 Original *	SFY 2010 Revised Final Order
Direct Medicaid Add-On payments	941,119,699	964,410,691	999,961,070
GME (Quarterly & Enhanced)	115,290,853	114,911,603	118,343,464
Total	1,056,410,552	1,079,322,294	1,118,304,534
Increased Cost: SFY 2010 Original - SFY 2009		22,911,742	
Increased Cost: SFY 2010 Revised - SFY 2010 Original			38,982,240

* The SFY 2010 Original includes items already provided for in rule (i.e., updating to a more current cost report base). In addition, this includes the cost of the proposed amendment (i.e., the 3.9% trend for SFY 2010, the 75% reduction in better of days and elimination of the utilization adjustment).

IV. ASSUMPTIONS

As a result of comments to the proposed amendment relating to the changes in the better of days calculation and the utilization adjustment, the division revised the proposed amendment in the final order of rulemaking to reduce the initial impact of these changes on hospitals and allow for a longer transition period. Effective for dates of service beginning January 1, 2010, the final order of rulemaking revises the better of days calculation for all hospitals and revises the utilization adjustment for all hospitals except for safety net hospitals, as follows:

- The proposed amendment reduced the better of days calculation by 75% and the order of rulemaking reduces the better of days calculation by 25%.
- The proposed amendment eliminated the utilization adjustment for all hospitals except for safety net hospitals and children's hospitals and the order of rulemaking provides for hospitals other than safety net hospitals to receive 67% of the utilization adjustment. Safety net hospitals will continue to receive 100% of the utilization adjustment.

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership and Benefits

ORDER OF RULEMAKING

By the authority vested in the County Employees' Retirement Fund Board of Directors under section 50.1032, RSMo 2000, the board amends a rule as follows:

16 CSR 50-2.035 Payment of Benefits **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 1, 2009 (34 MoReg 2146–2147). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 1—Financial Solvency and Accounting Standards

ORDER OF RULEMAKING

By the authority vested in the director of the Missouri Department of Insurance, Financial Institutions and Professional Registration under section 374.045, RSMo Supp. 2009, the director adopts a rule as follows:

20 CSR 200-1.105 Property and Casualty Actuarial Opinions **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 1, 2009 (34 MoReg 2154). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The director received testimony from Mark Stahlhuth, counsel for the Division of Insurance Company Regulation, in support of and explaining the proposed rule. No further testimony was offered at the hearing. The Reinsurance Association of America (RAA) wrote to support adoption of the proposed rule because it is based on the Property and Casualty Actuarial Opinion Model Law of the National Association Insurance Commissioners (NAIC) but suggested that the rule more closely conform to the language used in the NAIC model.
RESPONSE: The director appreciates RAA's comments but declines the suggestion because the director lacks rulemaking authority to adopt all the language of the NAIC model.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 400—Life, Annuities and Health
Chapter 3—Medicare Supplement Insurance

ORDER OF RULEMAKING

By the authority vested in the director of the Missouri Department of Insurance, Financial Institutions and Professional Registration under section 374.045, RSMo Supp. 2009, the director amends a rule as follows:

20 CSR 400-3.650 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on September 1, 2009 (34 MoReg 1805–1920). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code* of *State Regulations*.

SUMMARY OF COMMENTS: The director received one (1) letter containing three (3) comments on the proposed amendment from America's Health Insurance Plans (AHIP). AHIP later noted that the third comment no longer applied; therefore, only two (2) comments are included in this order of rulemaking.

COMMENT #1: AHIP requested that paragraph (5)(A)3. be amended to be consistent with the National Association of Insurance Commissioners Model Regulation which offers a technical amendment to update the language regarding Medicare deductible and copayment percentage factors.
RESPONSE AND EXPLANATION OF CHANGE: The director agrees with this comment and has modified the proposed amendment accordingly.

COMMENT #2: AHIP commented that the new amendments for paragraph (12)(B)1. establish a new qualifying event for eligibility to guarantee issue of Medicare supplement plans. The new qualifying event would be for a person enrolled under an employee welfare benefit plan that provides health benefits that supplement Medicare benefits when "the individual leaves the plan." AHIP noted that this provision is not related to changes required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) or the Genetic Information Non-Discrimination Act of 2008 (GINA), and it goes beyond the federal minimum standards. AHIP asked that the words "or the individual leaves the plan;" be deleted from paragraph (12)(B)1.
RESPONSE: The director appreciates this comment, but no changes have been made to the proposed amendment in response. The text referenced by AHIP is a Missouri-specific provision that was previously in the regulation for a number of years until it was mistakenly removed by a prior amendment. The director believes this provision previously provided Missouri consumers a necessary additional protection and should be reinserted, even though the language is not consistent with the NAIC Model Regulation.

20 CSR 400-3.650 Medicare Supplement Insurance Minimum Standards Act

(5) Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to July 30, 1992. No policy or certificate may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(A) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this rule.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

4. A "noncancelable," "guaranteed renewable," or "noncancelable and guaranteed renewable" Medicare supplement policy shall not—

A. Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

B. Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.

5.

A. Except as authorized by the director, an issuer shall neither cancel nor non-renew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

B. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subparagraph D. of this paragraph, the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:

(I) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(II) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in subsection (6)(B) of this rule.

C. If membership in a group is terminated, the issuer shall—

(I) Offer the certificate holder the conversion opportunities described in subparagraph 5.B. of this subsection; or

(II) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

D. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

6. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

7. If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2220—State Board of Pharmacy
Chapter 2—General Rules

ORDER OF RULEMAKING

By the authority vested in the State Board of Pharmacy under section 338.140.1, RSMo 2000, and section 338.380, RSMo Supp. 2009, the board adopts a rule as follows:

20 CSR 2220-2.175 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 1, 2009 (34 MoReg 2195–2203). The section with changes is reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations.*

SUMMARY OF COMMENTS: The board received three (3) comments on the proposed rule.

COMMENT#1: After further review, the board identified an incorrect citation in the purpose statement of the rule.
RESPONSE AND EXPLANATION OF CHANGE: The board voted to change the current citation from section 333.080, RSMo, to section 338.380, RSMo.

COMMENT #2: The board received a comment from Douglas Lang, RPh, a former board member and current member of the Missouri Society of Health-Systems Pharmacists, recommending that the board change paragraph (5)(D)2. of the rule to clarify that impaired licensees are prohibited from possessing or consuming any legal drug, unless prescribed by a physician. The current language only prohibits the possession/consumption of controlled substances without physician authorization. The commenter indicated that several non-controlled drugs may also be addictive and should be prohibited unless prescribed by a treating physician.
RESPONSE AND EXPLANATION OF CHANGE: The board reviewed and agreed with the proposed recommendation and has amended the proposed rule to reflect the change.

COMMENT #3: After further review, the board recommended amending paragraph (5)(D)3. to clarify the current language regarding the "possession" of alcohol. The board recognizes the importance of prohibiting an impaired licensee from consuming alcohol due to the high potential for abuse/addiction. This potential is especially prevalent for impaired licensees with confirmed impairment issues. However, after consulting with legal counsel, the board expressed concerns regarding the potential scope of the term "possession" in the absence of a precise definition. Accordingly, the board recommended that the rule be clarified to clearly reflect that impaired licensees participating in the Well-Being Committee are prohibited from the consumption of alcohol.
RESPONSE AND EXPLANATION OF CHANGE: The board reviewed and agreed with the proposed recommendation and has amended the proposed rule to reflect the change.

20 CSR 2220-2.175 Well-Being Program

PURPOSE: This rule establishes guidelines for the operation of the Well-Being Committee, pursuant to section 338.380, RSMo.

(5) Well-Being Committee Duties.

(D) The committee shall enter into written contracts with each impaired licensee. The contract between the committee and the impaired licensee shall be a minimum of five (5) years in duration, or the time designated by the board. The contract between the committee and impaired licensee shall include, but shall not be limited to, the following conditions/requirements:

1. Each impaired licensee shall comply with all terms, conditions, or treatment identified, required, or recommended by the contractor or the board for the treatment, evaluation, monitoring, or assessment of the impaired licensee;

2. Each impaired licensee shall abstain from the possession or

consumption of legend medication, except as prescribed by a treating prescriber;

3. Each impaired licensee shall abstain from illegal possession of alcohol, the consumption of alcohol, and the possession or consumption of illegal drugs;

4. Each impaired licensee shall submit to random drug testing unless otherwise specified by the board, committee, or contractor;

5. Each impaired licensee shall report to the committee or the contractor all relapses or other breaches of the contractual terms;

6. Each impaired licensee shall report to or meet with the board, committee, contractor, or the contractor's appointed designee as may be requested by the board, committee, or contractor;

7. Each impaired licensee shall attend support meetings as requested by the committee, contractor, or treatment providers;

8. Each impaired licensee referred to the Well-Being Program by the board shall authorize the committee to release any and all information regarding the impaired licensee to the board;

9. Each impaired licensee voluntarily enrolled in the Well-Being Program shall authorize the committee to release any and all information regarding the impaired licensee to the board upon a violation of any state or federal drug law or if the licensee breaches or fails to comply with any terms of a Well-Being contract; and

10. Each impaired licensee shall be financially responsible for all drug screens and any other professional or administrative service rendered on behalf of the impaired licensee.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2220—State Board of Pharmacy
Chapter 2—General Rules

ORDER OF RULEMAKING

By the authority vested in the State Board of Pharmacy under sections 338.013 and 338.380, RSMo Supp. 2009, and section 338.140, RSMo 2000, the board amends a rule as follows:

20 CSR 2220-2.700 Pharmacy Technician Registration **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 1, 2009 (34 MoReg 2204). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2245—Real Estate Appraisers
Chapter 3—Applications for Certification and Licensure

ORDER OF RULEMAKING

By the authority vested in the Real Estate Appraisers under section 339.509, RSMo 2000, and sections 339.515 and 339.517, RSMo Supp. 2009, the commission amends a rule as follows:

20 CSR 2245-3.010 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 1, 2009 (34 MoReg 2207–2208). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The commission received one (1) comment on the proposed amendment.

COMMENT #1: The Missouri Appraisers Advisory Council (MAAC) is in support of the proposed amendment. MAAC concurs with the proposed amendment because the classification "licensed appraiser" was originally intended to be a beginning practitioner/trainee license but has been used as a license that grants greater authority. Also, the amendment allows licensed appraisers to maintain their current license and includes a lengthy grace period for those still wishing to file an application for a "state licensed real estate appraiser." The Appraisal Qualifications Board also recognized the need in the current real estate environment to have better educated/trained appraisers and issued new educational standards effective January 1, 2008, which requires additional education for all levels. And as of October 1, 2009, the Federal Housing Administration (FHA) no longer allows "licensed appraisers" to complete FHA appraisals.

RESPONSE AND EXPLANATION OF CHANGE: The commission appreciates the support from MAAC. However, upon further review of the proposed amendment and sections 339.500 through 339.549, RSMo, the commission is withdrawing the proposed paragraph (5)(C)2.

20 CSR 2245-3.010 Applications for Certification and Licensure

(5) Prerequisite for Certification.

(C) State-Licensed Real Estate Appraiser.

1. As a prerequisite for licensure as a state-licensed real estate appraiser, an applicant shall present satisfactory evidence to the commission that the applicant possesses the equivalent of two thousand (2,000) hours of appraisal experience obtained over a period of not less than twelve (12) months under the supervision of a state-certified real estate appraiser and supported by adequate written reports or file memoranda. The applicant must have at least fifty percent (50%) of the required experience hours in the state of Missouri. Hours may be treated as cumulative in order to achieve the necessary two thousand (2,000) hours of appraisal experience.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2245—Real Estate Appraisers
Chapter 4—Certificates and Licenses

ORDER OF RULEMAKING

By the authority vested in the Real Estate Appraisers under sections 339.509 and 339.523, RSMo 2000, and section 339.521, RSMo Supp. 2009, the commission withdraws a proposed amendment as follows:

20 CSR 2245-4.050 Nonresident Certification or Licensure; Reciprocity **is withdrawn**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 1, 2009 (34 MoReg 2208). This proposed amendment is withdrawn.

SUMMARY OF COMMENTS: The commission made one (1) comment on the proposed amendment.

COMMENT: Upon further review of the proposed amendment and sections 339.500 through 339.549, RSMo, the commission decided to withdraw the proposed amendment.
RESPONSE: The commission requests the proposed amendment be withdrawn.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2245—Real Estate Appraisers
Chapter 4—Certificates and Licenses

ORDER OF RULEMAKING

By the authority vested in the Real Estate Appraisers under section 339.509, RSMo 2000 and sections 339.503 and 339.521, RSMo Supp. 2009, the commission withdraws a proposed amendment as follows:

20 CSR 2245-4.060 Temporary Nonresident Certificate or License **is withdrawn**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 1, 2009 (34 MoReg 2208–2209). This proposed amendment is withdrawn.

SUMMARY OF COMMENTS: The commission made one (1) comment on the proposed amendment.

COMMENT: Upon further review of the proposed amendment and sections 339.500 through 339.549, RSMo, the commission decided to withdraw the proposed amendment.
RESPONSE: The commission requests the proposed amendment be withdrawn.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2245—Real Estate Appraisers
Chapter 6—Educational Requirements

ORDER OF RULEMAKING

By the authority vested in the Real Estate Appraisers under section 339.509, RSMo 2000, and section 339.517, RSMo Supp. 2009, the commission withdraws a proposed amendment as follows:

20 CSR 2245-6.015 Examination and Education Requirements **is withdrawn**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 1, 2009 (34 MoReg 2213). This proposed amendment is withdrawn.

SUMMARY OF COMMENTS: The commission made one (1) comment on the proposed amendment.

COMMENT: Upon further review of the proposed amendment and sections 339.500 through 339.549, RSMo, the commission decided to withdraw the proposed amendment.
RESPONSE: The commission requests the proposed amendment be withdrawn.

This section may contain notice of hearings, correction notices, public information notices, rule action notices, statements of actual costs, and other items required to be published in the *Missouri Register* by law.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 7—Wildlife Code: Hunting: Seasons, Methods, Limits

IN ADDITION

3 CSR 10-7.455 Turkeys: Seasons, Methods, Limits

As a matter of public information, the following dates and bag limits shall apply to turkey hunting seasons for 2010. These are based on the formula for season dates set out in subsections (1)(A), (1)(B), and (1)(D) of this rule in the *Code of State Regulations* and actions of the Conservation Commission on December 17, 2009, to annually establish the season length and bag limit of the spring, fall, and youth hunting seasons.

Spring Season: The 2010 spring turkey hunting season will be twenty-one (21) days in length (April 19–May 9, 2010). A person possessing the prescribed turkey hunting permit may take two (2) male turkeys or turkeys with visible beards during the season; provided, only one (1) turkey may be taken the first seven (7) days of the season (April 19 through April 25), and only one (1) turkey may be taken per day from April 26 through May 9. Shooting hours: one-half (½) hour before sunrise to 1:00 p.m. Central Daylight Saving Time.

Youth Spring Season Dates: April 10–11, 2010. A youth possessing the prescribed youth turkey hunting permit and is at least six (6) but not older than fifteen (15) years of age may take one (1) male turkey or turkey with visible beard. Shooting hours: one-half (½) hour before sunrise to sunset, Central Daylight Saving Time.

Fall Season: The 2010 fall turkey hunting season will be thirty-one (31) days in length (October 1–October 31, 2010). Two (2) turkeys of either sex may be taken during the season. Shooting hours: one-half (½) hour before sunrise to sunset, Central Daylight Saving Time.

Title 7—DEPARTMENT OF TRANSPORTATION
Division 10—Missouri Highways and Transportation Commission
Chapter 25—Motor Carrier Operations

IN ADDITION

7 CSR 10-25.010 Skill Performance Evaluation Certificates for Commercial Drivers

PUBLIC NOTICE

Public Notice and Request for Comments on Applications for Issuance of Skill Performance Evaluation Certificates to Intrastate Commercial Drivers with Diabetes Mellitus or Impaired Vision

SUMMARY: This notice publishes MoDOT's receipt of applications for the issuance of Skill Performance Evaluation (SPE) Certificates from individuals who do not meet the physical qualification requirements in the Federal Motor Carrier Safety Regulations for drivers of commercial motor vehicles in Missouri intrastate commerce, because of impaired vision or an established medical history or clinical diagnosis of diabetes mellitus currently requiring insulin for control. If granted, the SPE Certificates will authorize these individuals to qualify as drivers of commercial motor vehicles (CMVs), in intrastate commerce only, without meeting the vision standard prescribed in 49 CFR 391.41(b)(10), if applicable, or the diabetes standard prescribed in 49 CFR 391.41(b)(3).

DATES: Comments must be received at the address stated below, on or before February 15, 2010.

ADDRESSES: You may submit comments concerning an applicant, identified by the Application Number stated below, by any of the following methods:
- *Email:* Kathy.Hatfield@modot.mo.gov
- *Mail:* PO Box 893, Jefferson City, MO 65102-0893
- *Hand Delivery:* 1320 Creek Trail Drive, Jefferson City, MO 65109
- *Instructions:* All comments submitted must include the agency name and Application Number for this public notice. For detailed instructions on submitting comments, see the Public Participation heading of the Supplementary Information section of this notice. All comments received will be open and available for public inspection and MoDOT may publish those comments by any available means.

COMMENTS RECEIVED BECOME MoDOT PUBLIC RECORD

- By submitting any comments to MoDOT, the person authorizes MoDOT to publish those comments by any available means.
- *Docket:* For access to the department's file, to read background documents or comments received, 1320 Creek Trail Drive, Jefferson City, MO 65109, between 7:30 a.m. and 4:00 p.m., CT, Monday through Friday, except state holidays.

FOR FURTHER INFORMATION CONTACT: Ms. Kathy Hatfield, Motor Carrier Specialist, (573) 522-9001, MoDOT Motor Carrier Services Division, PO Box 893, Jefferson City, MO 65102-0893. Office hours are from 7:30 a.m. to 4:00 p.m., CT, Monday through Friday, except state holidays.

SUPPLEMENTARY INFORMATION:

Public Participation
If you want us to notify you that we received your comments, please include a self-addressed, stamped envelope or postcard.

Background
The individuals listed in this notice have recently filed applications requesting MoDOT to issue SPE Certificates to exempt them from the physical qualification requirements relating to vision in 49 CFR 391.41(b)(10) or to diabetes in 49 CFR 391.41(b)(3), which otherwise apply to drivers of CMVs in Missouri intrastate commerce.

Under section 622.555, RSMo Supp. 2009, MoDOT may issue a Skill Performance Evaluation Certificate, for not more than a two (2)-year period, if it finds that the applicant has the ability, while operating CMVs, to maintain a level of safety that is equivalent to or greater than the driver qualification standards of 49 CFR 391.41. Upon application, MoDOT may renew an exemption upon expiration.

Accordingly, the agency will evaluate the qualifications of each applicant to determine whether issuing a SPE Certificate will comply with the statutory requirements and will achieve the required level of safety. If granted, the SPE Certificate is only applicable to intrastate transportation wholly within Missouri.

Qualifications of Applicants

Application # MP070323014

Renewal Applicant's Name & Age: Robert Ogle, Jr., 50

Relevant Physical Condition: Mr. Ogle's best corrected visual acuity in his left eye is 20/20 Snellen, and he is blind in his right eye.

Relevant Driving Experience: Mr. Ogle is currently employed with a water company and has been for over eleven (11) years. Mr. Ogle indicated that he has over twelve (12) years' commercial motor vehicle driving experience. He currently has a Class A driver's license. Drives personal vehicle(s) daily.

Doctor's Opinion & Date: Following an examination in November 2009, his optometrist certified, "In my medical opinion, Mr. Ogle's visual deficiency is stable and has sufficient vision to perform the driving tasks required to operate a commercial motor vehicle and that his condition will not adversely affect his ability to operate a commercial motor vehicle safely."

Traffic Accidents and Violations: No accidents or violations on record.

Application # MP070129006

Applicant's Name & Age: Dominic J. Bennett, 25

Relevant Physical Condition: Mr. Bennett's best-corrected visual acuity in his left eye is 20/200 Snellen, and his right eye is 20/20 Snellen uncorrected. He was diagnosed with amblyopia of the left eye in January 2007.

Relevant Driving Experience: Mr. Bennett has been employed with a water company in the St. Louis area since August 2005. He drives a dump truck and pulls a trailer. Drives personal vehicle(s) daily.

Doctor's Opinion & Date: Following an examination in December 2009, his optometrist certified, "In my medical opinion, Mr. Bennett's visual deficiency is stable, he has sufficient vision to perform the driving tasks required to operate a commercial motor vehicle, and the applicant's condition will not adversely affect his ability to operate a commercial motor vehicle safely."

Traffic Accidents and Violations: No accidents or violations within the past three (3) years.

Application # MP091210049

Applicant's Name & Age: Christopher L. Woodward, 27

Relevant Physical Condition: Mr. Woodward's best uncorrected visual acuity is 20/20 Snellen in his right eye and 20/30 Snellen in his left eye. Mr. Woodward was diagnosed with Insulin Treated Diabetes Mellitus in 1982 at the age of two (2).

Relevant Driving Experience: Employed in Carrollton, Missouri, as a grain hauler and has approximately six (6) years experience driving commercial motor vehicles. Drives personal vehicle(s) daily.

Doctor's Opinion & Date: Following an examination in November 2009, his endocrinologist certified, "In my medical opinion, Mr. Woodward's diabetes deficiency is stable, he is capable of performing the driving tasks required to operate a commercial motor vehicle, and the applicant's condition will not adversely affect his ability to operate a commercial motor vehicle safely."

Traffic Accidents and Violations: No accidents or violations within the past three (3) years.

Application # MP050121003

Applicant's Name & Age: Charles F. Ferrell, 76

Relevant Physical Condition: Mr. Ferrell's best-corrected visual acuity in both eyes is 20/30 Snellen. He has insulin-treated diabetes mellitus and has been using insulin for control since 1995.

Relevant Driving Experience: Mr. Ferrell has driven nearly thirty-four (34) years for private industry and through self-employment. He has driven straight trucks, tractor-trailer combinations, doubles, vans, flat beds, and tanks both manual and automatic. He has been semi-retired and obtained the seasonal CDL for several years to drive farm vehicles. He now wishes to drive the farm vehicles on a regular basis. Drives personal vehicle(s) daily.

Doctor's Opinion & Date: Following an examination in December 2009, his endocrinologist certified, "In my medical opinion, Mr. Ferrell's diabetes deficiency is stable, he is capable of performing the driving tasks required to operate a commercial motor vehicle, and the applicant's condition will not adversely affect his ability to operate a commercial motor vehicle safely."

Traffic Accidents and Violations: No accidents or violations within the past three (3) years.

Request for Comments
The Missouri Department of Transportation, Motor Carrier Services Division, pursuant to section 622.555, RSMo, and rule 7 CSR 10-25.010, requests public comment from all interested persons on the applications for issuance of Skill Performance Evaluation Certificates described in this notice. We will consider all comments received before the close of business on the closing date indicated earlier in this notice.

Issued on: December 15, 2009

Jan Skouby, Motor Carrier Services Director, Missouri Department of Transportation.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

NOTIFICATION OF REVIEW: APPLICATION REVIEW SCHEDULE

The Missouri Health Facilities Review Committee has initiated review of the expedited applications listed below. A decision is tentatively scheduled for February 23, 2010. These applications are available for public inspection at the address shown below:

Date Filed
Project Number: Project Name
City (County)
Cost, Description

01/08/10
#4453 HS: Alexian Brothers Sherbrooke Village
St. Louis (St. Louis County)
$7,750,000, Long-term care (LTC) expansion through the purchase of 35 skilled nursing facility (SNF) beds from Alexian Brothers Lansdowne Village, St. Louis.

01/12/10
#4454 RS: Alexian Brothers Sherbrooke Village
St. Louis (St. Louis County)
$3,100,000, Renovate/modernize LTC facility

#4469 NS: Festus Manor
Festus (Jefferson County)
$2,682,914, LTC expansion through the purchase of 30 SNF beds from Twin Pines Adult Care Center, Kirksville

Any person wishing to request a public hearing for the purpose of commenting on these applications must submit a written request to this effect, which must be received by February 11, 2010. All written requests and comments should be sent to:

Chairman
Missouri Health Facilities Review Committee
c/o Certificate of Need Program
3418 Knipp Drive, Suite F
Post Office Box 570
Jefferson City, MO 65102

For additional information contact
Donna Schuessler, (573) 751-6403.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

IN ADDITION

Pursuant to section 537.610, RSMo, regarding the Sovereign Immunity Limits for Missouri Public Entities, the Director of Insurance, Financial Institutions and Professional Registration is required to calculate the new limits on awards for liability.

Using Implicit Price Deflator (IPD) for Personal Consumption Expenditures (PCE), as required by section 573.610, RSMo, the two (2) new Sovereign Immunity Limits effective January 1, 2010, were established by the following calculations:

Index Based on 2005 Dollars	
Third Quarter 2008 IPD Index	110.276
Third Quarter 2009 IPD Index	109.567

New 2010 Limit = 2009 Limit × (2009 Index/2008 Index)

For all claims arising out of a single accident or occurrence:
2,509,186 = 2,525,423 × (109.567/110.276)

For any one (1) person in a single accident or occurrence:
376,378 = 378,814 × (109.567/110.276)

STATUTORY LIST OF CONTRACTORS BARRED FROM PUBLIC WORKS PROJECTS

The following is a list of contractor(s) who have been prosecuted and convicted of violating the Missouri Prevailing Wage Law and whose Notice of Conviction has been filed with the Secretary of State pursuant to section 290.330, RSMo. Under this statute, no public body is permitted to award a contract, directly or indirectly, for public works 1) to Michael B. Robin, 2) to any other contractor or subcontractor that is owned, operated, or controlled by Mr. Robin, including Plumbco, Inc., or 3) to any other simulation of Mr. Robin or of Plumbco, Inc., for a period of one (1) year, or until December 17, 2010.

Name of Contractor	Name of Officers	Address	Date of Conviction	Debarment Period
Michael B. Robin DBA Plumbco, Inc. Case No. 09AO-CR01174		7534 Heron Drive Neosho, MO 64804	12/17/09	12/17/2009–12/17/2010

The Secretary of State is required by sections 347.141 and 359.481, RSMo 2000, to publish dissolutions of limited liability companies and limited partnerships. The content requirements for the one-time publishing of these notices are prescribed by statute. This listing is published pursuant to these statutes. We request that documents submitted for publication in this section be submitted in camera ready 8 1/2" x 11" manuscript by email to dissolutions@sos.mo.gov.

NOTICE OF CORPORATE DISSOLUTION TO ALL CREDITORS OF AND CLAIMANTS AGAINST FAMILY MEDICAL CARE ASSOCIATES, P.C.

On December 18, 2009, Family Medical Care Associates, P.C. filed it Articles of Dissolution with the Missouri Secretary of State. The dissolution was effective on the date of the filing of the Articles of Dissolution with the Missouri Secretary of State.

You are hereby notified that if you believe that you have a claim against Family Medical Care Associates, P.C. you must submit a summary in writing of the circumstances surrounding your claim to the corporation in care of Kimberley S. Spies, Esq. at King Hershey, PC, 2345 Grand Boulevard, Suite 2100, Kansas City, Missouri 64108. A summary of your claim must include the following information:

1. The name, address and telephone number of the claimant.
2. The monetary value of the claim.
3. The date of the event in which the claim(s) is based.
4. A brief description of the nature of the debt or the basis for the claim.

All claims against Family Medical Care Associates, P.C. will be barred unless the proceedings to enforce the claim are commenced within two years after publication of this notice.

NOTICE OF DISSOLUTION OF CORPORATION TO ALL CREDITORS OF AND CLAIMANTS AGAINST HOUSE OF POWER, INC.

On December 14, 2009, House of Power, Inc., a Missouri corporation, filed its Articles of Dissolution for corporation with the Missouri Secretary of State, effective on the filing date.

House of Power, Inc., requests that all persons and organizations who have claims against it present them immediately by letter to the House of Power, Inc., management at: 10600 East Route Y, Ashland, MO 65010. All claims must include the name and address of the claimant; the amount of the claim; the basis for the claim; the date on which the claim arose; and documentation for the claim.

All claims against House of Power, Inc., will be barred unless the proceeding to enforce the claim is commenced within two (2) years after the publication of this notice.

NOTICE OF DISSOLUTION AND WINDING UP
TO ALL CREDITORS OF AND CLAIMANTS AGAINST
WEBSTER GROVES PARTNERS, L.P.

On December 14, 2009, WEBSTER GROVES PARTNERS, L.P., a Missouri limited partnership, was dissolved upon the filing of a Certificate of Cancellation with the Secretary of State.

Said partnership requests that all persons and organizations who have claims against it present them immediately by letter to: O. Bruce Mills, Mills Group, Inc., 120 South Central Avenue, Clayton, Missouri 63105. All claims must include the claimant's name, address and telephone number, the amount, date and basis for the claim.

ANY CLAIMS AGAINST WEBSTER GROVES PARTNERS, L.P. WILL BE BARRED UNLESS A PROCEEDING TO ENFORCE THE CLAIM IS COMMENCED WITHIN THREE YEARS AFTER THE LAST PUBLICATION DATE OF THE NOTICES AUTHORIZED BY STATUTE.

NOTICE OF DISSOLUTION OF CCP ACQUISITION LIMITED

On December 29, 2009, CCP Acquisition Limited, a Missouri corporation (the "Company"), filed its Articles of Dissolution with the Missouri Secretary of State. The dissolution of the Company was effective on December 29, 2009.

The Company requests that all persons and entities with claims against the Company present them in accordance with this notice.

All claims against the Company must be in writing and must include the name, address and telephone number of the claimant, the amount of the claim or other relief demanded, the basis of the claim, the date or dates on which the events occurred which provide a basis for the claim, and copies of any available document supporting the claim. All claims should be mailed to c/o Christine M. Noonan, 101South Hanley, Suite 1250, St. Louis, Missouri 63105.

Any claim against the Company will be barred unless a proceeding to enforce the claim is commenced within two years after the publication of this notice.

NOTICE OF WINDING UP OF CCP HOLDINGS, LLC

On December 29, 2009, CCP HOLDINGS, LLC, a Missouri limited liability company (the "Company"), filed its Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State. The dissolution of the Company was effective on December 29, 2009.

The Company requests that all persons and entities with claims against the Company present them in accordance with this notice.

All claims against the Company must be in writing and must include the amount of the claim, the basis of the claim, and copies of any documentation for the claim. All claims should be mailed to c/o Christine M. Noonan, 101 South Hanley, Suite 1250, St. Louis, Missouri 63105.

A claim against the Company will be barred unless a proceeding to enforce the claim is commenced within three years after the publication of this notice.

NOTICE OF WINDING UP OF BDH HOLDINGS, LLC

On December 30, 2009, BDH HOLDINGS, LLC, a Missouri limited liability company (the "Company"), filed its Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State. The dissolution of the Company was effective on December 30, 2009.

The Company requests that all persons and entities with claims against the Company present them in accordance with this notice.

All claims against the Company must be in writing and must include the amount of the claim, the basis of the claim, and copies of any documentation for the claim. All claims should be mailed to c/o Christine M. Noonan, 101 South Hanley, Suite 1250, St. Louis, Missouri 63105.

A claim against the Company will be barred unless a proceeding to enforce the claim is commenced within three years after the publication of this notice.

NOTICE OF WINDING UP OF SAFETY BY DESIGN, LLC

On December 30, 2009, SAFETY BY DESIGN, LLC, a Missouri limited liability company (the "Company"), filed its Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State. The dissolution of the Company was effective on December 30, 2009.

The Company requests that all persons and entities with claims against the Company present them in accordance with this notice.

All claims against the Company must be in writing and must include the amount of the claim, the basis of the claim, and copies of any documentation for the claim. All claims should be mailed to c/o Christine M. Noonan, 101 South Hanley, Suite 1250, St. Louis, Missouri 63105.

A claim against the Company will be barred unless a proceeding to enforce the claim is commenced within three years after the publication of this notice.

NOTICE OF CORPORATE DISSOLUTION TO ALL CREDITORS OF AND CLAIMANTS AGAINST LIFESCREEN, INC.

On December 18, 2009, LifeScreen, Inc., a Missouri close corporation (the "Corporation"), filed its Articles of Dissolution with the Missouri Secretary of State. All persons and organizations with claims against the Corporation must submit to LifeScreen, Inc., 2101 Corona Road, Suite 201, Columbia, MO 65203, a written summary of any claims against the Corporation which shall include the name, address, and telephone numbers of the claimant, the amount of the claim, date(s) the claim accrued, a brief description of the nature/basis for the claim, and any documentation of the claim. Claims against the Corporation will be barred unless a proceeding to enforce the claim is commenced within 2 years after the publication of this notice.

NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST ENDOSCREEN, LLC

On December 21, 2009, EndoScreen, LLC, a Missouri limited liability company (the "Company"), filed its Notice of Winding Up with the Missouri Secretary of State. All persons and organizations with claims against the Company must submit to EndoScreen, LLC, 2101 Corona Road, Suite 201, Columbia, MO 65203, a written summary of any claims against the Company which shall include the name, address, and telephone numbers of the claimant, the amount of the claim, date(s) the claim accrued, a brief description of the nature/basis for the claim, and any documentation of the claim. Claims against the Company will be barred unless a proceeding to enforce the claim is commenced within 3 years after the publication of this notice.

NOTICE OF CORPORATE DISSOLUTION

TO ALL CREDITORS OF AND CLAIMANTS AGAINST

THE DATARECTORY COMPANY, INC.

Effective 12/31/2009, THE DATARECTORY COMPANY, INC., a Missouri corporation (the "Company"), filed its Articles of Dissolution with the Missouri Secretary of State and was voluntarily dissolved.

The Company requests that all persons and entities with claims against the Company present them in accordance with this notice.

All claims against the Company must be in writing and must include the name, address and telephone number of the claimant, the amount of the claim or other relief demanded, the basis of the claim, the date or dates on which the events occurred which provide a basis for the claim, and copies of any available document supporting the claim. All claims should be mailed to: The Datarectory Company, Inc., c/o Stephen Hearn, 1807 Park 270 Drive, Suite 300, St. Louis, MO 63146.

Any claim against the Company will be barred unless a proceeding to enforce the claim is commenced within two (2) years after the publication of this notice.

NOTICE OF DISSOLUTION OF CORPORATION

This notice is to inform whom it may concern that Schoen Holdings, Inc., has on the 17th day of December, 2009, filed with, and received approval by the Missouri Secretary of State the corporation's Articles of Dissolution. Dissolution was effective on December 17, 2009.

Any claims against the corporation should be forwarded to the corporation's attorney at the following address:

Schoen Holdings, Inc.

c/o: Seigfreid, Bingham, Levy, Selzer & Gee, P.C.

Attention: Timothy J. Fisher

911 Main Street, Suite 2800

Kansas City, Missouri 64105

The claim must include the following information: (1) the name, address and telephone number of the claimant; (2) the amount of the claim; (3) the date the claim accrued or will accrue; (4) a brief description of the nature of the debt or the basis for the claim; (5) whether the claim is secured, and if so, the collateral used as security.

You are further notified that all claims against the corporation shall be barred unless a proceeding to enforce the claim is commenced within two years after the publication of this notice.

Rule Changes Since Update to Code of State Regulations

This cumulative table gives you the latest status of rules. It contains citations of rulemakings adopted or proposed after deadline for the monthly Update Service to the *Code of State Regulations*, citations are to volume and page number in the *Missouri Register*, except for material in this issue. The first number in the table cite refers to the volume number or the publication year—30 (2005) and 31 (2006). MoReg refers to *Missouri Register* and the numbers refer to a specific *Register* page, R indicates a rescission, W indicates a withdrawal, S indicates a statement of actual cost, T indicates an order terminating a rule, N.A. indicates not applicable, RAN indicates a rule action notice, RUC indicates a rule under consideration, and F indicates future effective date.

Rule Number	Agency	Emergency	Proposed	Order	In Addition
	OFFICE OF ADMINISTRATION				
1 CSR 10	State Officials' Salary Compensation Schedule				30 MoReg 2435
1 CSR 20-4.010	Personnel Advisory Board and Division of Personnel		35 MoReg 98		
	DEPARTMENT OF AGRICULTURE				
2 CSR 30-2.010	Animal Health		34 MoReg 1461	34 MoReg 2597	
2 CSR 30-2.020	Animal Health		34 MoReg 1468	34 MoReg 2598	
2 CSR 30-6.015	Animal Health		34 MoReg 1474	34 MoReg 2600	
2 CSR 30-6.020	Animal Health		34 MoReg 1475	34 MoReg 2600	
2 CSR 80-2.010	State Milk Board		34 MoReg 1788	34 MoReg 2546	
2 CSR 80-2.020	State Milk Board		34 MoReg 1788	34 MoReg 2546	
2 CSR 80-2.030	State Milk Board		34 MoReg 1789	34 MoReg 2546	
2 CSR 80-2.040	State Milk Board		34 MoReg 1789	34 MoReg 2546	
2 CSR 80-2.050	State Milk Board		34 MoReg 1790	34 MoReg 2546	
2 CSR 80-2.060	State Milk Board		34 MoReg 1790	34 MoReg 2547	
2 CSR 80-2.070	State Milk Board		34 MoReg 1790	34 MoReg 2547	
2 CSR 80-2.080	State Milk Board		34 MoReg 1793	34 MoReg 2547	
2 CSR 80-2.091	State Milk Board		34 MoReg 1793	34 MoReg 2547	
2 CSR 80-2.101	State Milk Board		34 MoReg 1794	34 MoReg 2547	
2 CSR 80-2.110	State Milk Board		34 MoReg 1794	34 MoReg 2547	
2 CSR 80-2.121	State Milk Board		34 MoReg 1794	34 MoReg 2548	
2 CSR 80-2.130	State Milk Board		34 MoReg 1795	34 MoReg 2548	
2 CSR 80-2.141	State Milk Board		34 MoReg 1795	34 MoReg 2548	
2 CSR 80-2.151	State Milk Board		34 MoReg 1796	34 MoReg 2548	
2 CSR 80-2.161	State Milk Board		34 MoReg 1796	34 MoReg 2548	
2 CSR 80-2.170	State Milk Board		34 MoReg 1796	34 MoReg 2548	
2 CSR 90-10	Weights and Measures				34 MoReg 1949
2 CSR 100-6.010	Missouri Agricultural and Small Business Development Authority	34 MoReg 2527	35 MoReg 7		
	DEPARTMENT OF CONSERVATION				
3 CSR 10-4.135	Conservation Commission		34 MoReg 2364	35 MoReg 114	
3 CSR 10-5.422	Conservation Commission		34 MoReg 2364R	35 MoReg 114R	
3 CSR 10-5.435	Conservation Commission		34 MoReg 1985	34 MoReg 2601	
3 CSR 10-6.410	Conservation Commission		34 MoReg 2365	35 MoReg 114	
3 CSR 10-6.550	Conservation Commission		34 MoReg 2365	35 MoReg 114	
3 CSR 10-7.455	Conservation Commission				This Issue
3 CSR 10-8.515	Conservation Commission		34 MoReg 2365	35 MoReg 114	
3 CSR 10-9.110	Conservation Commission		34 MoReg 2366	35 MoReg 115	
3 CSR 10-9.353	Conservation Commission		34 MoReg 2367	35 MoReg 115	
3 CSR 10-9.425	Conservation Commission		34 MoReg 2367	35 MoReg 115	
3 CSR 10-9.645	Conservation Commission		34 MoReg 2368	35 MoReg 115	
3 CSR 10-10.725	Conservation Commission		34 MoReg 2368	35 MoReg 115	
3 CSR 10-10.726	Conservation Commission		34 MoReg 2368	35 MoReg 115	
3 CSR 10-10.727	Conservation Commission		34 MoReg 2369	35 MoReg 116	
3 CSR 10-10.767	Conservation Commission		34 MoReg 2369	35 MoReg 116	
3 CSR 10-10.780	Conservation Commission		34 MoReg 2370R	35 MoReg 116R	
3 CSR 10-10.781	Conservation Commission		34 MoReg 2370R	35 MoReg 116R	
3 CSR 10-10.782	Conservation Commission		34 MoReg 2370R	35 MoReg 116R	
3 CSR 10-10.783	Conservation Commission		34 MoReg 2370R	35 MoReg 116R	
3 CSR 10-10.784	Conservation Commission		34 MoReg 2371R	35 MoReg 117R	
3 CSR 10-10.787	Conservation Commission		34 MoReg 2371R	35 MoReg 117R	
3 CSR 10-11.130	Conservation Commission		34 MoReg 2371	35 MoReg 117	
3 CSR 10-11.155	Conservation Commission		34 MoReg 2372	35 MoReg 117	
3 CSR 10-11.180	Conservation Commission		34 MoReg 2373	35 MoReg 117	
3 CSR 10-11.200	Conservation Commission		34 MoReg 2374	35 MoReg 117	
3 CSR 10-11.205	Conservation Commission		34 MoReg 2375	35 MoReg 118	
3 CSR 10-11.210	Conservation Commission		34 MoReg 2376	35 MoReg 118	
3 CSR 10-11.215	Conservation Commission		34 MoReg 2377	35 MoReg 118	
3 CSR 10-12.110	Conservation Commission		34 MoReg 2378	35 MoReg 118	
3 CSR 10-12.125	Conservation Commission		34 MoReg 2378	35 MoReg 118	
3 CSR 10-12.130	Conservation Commission		34 MoReg 2379	35 MoReg 118	
3 CSR 10-12.135	Conservation Commission		34 MoReg 2379	35 MoReg 119	
3 CSR 10-12.140	Conservation Commission		34 MoReg 2380	35 MoReg 119	
3 CSR 10-12.145	Conservation Commission		34 MoReg 2381	35 MoReg 119	

Rule Number	Agency	Emergency	Proposed	Order	In Addition
	DEPARTMENT OF ECONOMIC DEVELOPMENT				
4 CSR 85-6.010	Division of Business and Community Services	34 MoReg 2353	34 MoReg 2381		
4 CSR 240-3.190	Public Service Commission		This Issue		
4 CSR 240-3.545	Public Service Commission		This Issue		
4 CSR 240-4.020	Public Service Commission		34 MoReg 2590R 34 MoReg 2590		
4 CSR 240-33.160	Public Service Commission		This Issue		
	DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION				
5 CSR 50-270.010	Division of School Improvement		This Issue		
5 CSR 50-345.105	Division of School Improvement		34 MoReg 2141		
5 CSR 50-345.205	Division of School Improvement		34 MoReg 2144		
5 CSR 60-100.020	Division of Career Education		This Issue		35 MoReg 59
	DEPARTMENT OF HIGHER EDUCATION				
6 CSR 250-11.041	University of Missouri	This Issue	34 MoReg 2592		
6 CSR 250-11.042	University of Missouri		34 MoReg 2594		
	DEPARTMENT OF TRANSPORTATION				
7 CSR 10-11.010	Missouri Highways and Transportation Commission		34 MoReg 1483	34 MoReg 2601	
7 CSR 10-11.020	Missouri Highways and Transportation Commission		34 MoReg 1484R 34 MoReg 1484	34 MoReg 2601R 34 MoReg 2601	
7 CSR 10-11.030	Missouri Highways and Transportation Commission		34 MoReg 1487R 34 MoReg 1487	34 MoReg 2602R 34 MoReg 2602	
7 CSR 10-25.010	Missouri Highways and Transportation Commission				34 MoReg 2615 This Issue
7 CSR 10-27.010	Missouri Highways and Transportation Commission		34 MoReg 2315		
7 CSR 10-27.020	Missouri Highways and Transportation Commission		34 MoReg 2317		
7 CSR 10-27.030	Missouri Highways and Transportation Commission		34 MoReg 2319		
7 CSR 10-27.040	Missouri Highways and Transportation Commission		34 MoReg 2321		
	DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS				
8 CSR 10-2.010	Division of Employment Security		34 MoReg 1985	35 MoReg 21	
8 CSR 10-3.140	Division of Employment Security		34 MoReg 2145	35 MoReg 119	
8 CSR 50-1.010	Division of Workers' Compensation		34 MoReg 2467		
	DEPARTMENT OF MENTAL HEALTH				
9 CSR 10-31.011	Director, Department of Mental Health		35 MoReg 8		
9 CSR 30-4.0432	Certification Standards		34 MoReg 1986	This Issue	
	DEPARTMENT OF NATURAL RESOURCES				
10 CSR 1-3.010	Director's Office		34 MoReg 2385		
10 CSR 10-6.010	Air Conservation Commission		34 MoReg 2385		
10 CSR 10-6.040	Air Conservation Commission		34 MoReg 2387		
10 CSR 10-6.050	Air Conservation Commission		34 MoReg 2594		
10 CSR 10-6.070	Air Conservation Commission		34 MoReg 2387		
10 CSR 10-6.075	Air Conservation Commission		34 MoReg 2389		
10 CSR 10-6.080	Air Conservation Commission		34 MoReg 2392		
10 CSR 10-6.130	Air Conservation Commission		34 MoReg 2392		
10 CSR 10-6.362	Air Conservation Commission		34 MoReg 1541	35 MoReg 21	
10 CSR 10-6.364	Air Conservation Commission		34 MoReg 1548	35 MoReg 22	
10 CSR 10-6.366	Air Conservation Commission		34 MoReg 1552	35 MoReg 22	
10 CSR 10-6.390	Air Conservation Commission		34 MoReg 2145		
10 CSR 20-4.040	Clean Water Commission	34 MoReg 1326	34 MoReg 1398	35 MoReg 119	
10 CSR 20-7.015	Clean Water Commission		34 MoReg 2394		
10 CSR 20-10.010	Clean Water Commission *(Changed to 10 CSR 26-2.010)*		34 MoReg 843	35 MoReg 23W	
10 CSR 20-10.011	Clean Water Commission *(Changed to 10 CSR 26-2.011)*		34 MoReg 845	35 MoReg 24W	
10 CSR 20-10.012	Clean Water Commission *(Changed to 10 CSR 26-2.012)*		34 MoReg 845	35 MoReg 24W	
10 CSR 20-10.020	Clean Water Commission *(Changed to 10 CSR 26-2.020)*		34 MoReg 847	35 MoReg 25W	
10 CSR 20-10.021	Clean Water Commission *(Changed to 10 CSR 26-2.021)*		34 MoReg 849	35 MoReg 25W	
10 CSR 20-10.022	Clean Water Commission *(Changed to 10 CSR 26-2.022)*		34 MoReg 849	35 MoReg 26W	
10 CSR 20-10.030	Clean Water Commission *(Changed to 10 CSR 26-2.030)*		34 MoReg 850	35 MoReg 26W	
10 CSR 20-10.031	Clean Water Commission *(Changed to 10 CSR 26-2.031)*		34 MoReg 851	35 MoReg 26W	
10 CSR 20-10.032	Clean Water Commission *(Changed to 10 CSR 26-2.032)*		34 MoReg 851	35 MoReg 26W	
10 CSR 20-10.033	Clean Water Commission *(Changed to 10 CSR 26-2.033)*		34 MoReg 851	35 MoReg 26W	
10 CSR 20-10.034	Clean Water Commission *(Changed to 10 CSR 26-2.034)*		34 MoReg 852	35 MoReg 27W	
10 CSR 20-10.040	Clean Water Commission *(Changed to 10 CSR 26-2.040)*		34 MoReg 853	35 MoReg 27W	

Rule Number	Agency	Emergency	Proposed	Order	In Addition
10 CSR 20-10.041	Clean Water Commission *(Changed to 10 CSR 26-2.041)*		34 MoReg 854	35 MoReg 27W	
10 CSR 20-10.042	Clean Water Commission *(Changed to 10 CSR 26-2.042)*		34 MoReg 854	35 MoReg 27W	
10 CSR 20-10.043	Clean Water Commission *(Changed to 10 CSR 26-2.043)*		34 MoReg 855	35 MoReg 28W	
10 CSR 20-10.044	Clean Water Commission *(Changed to 10 CSR 26-2.044)*		34 MoReg 857	35 MoReg 28W	
10 CSR 20-10.045	Clean Water Commission *(Changed to 10 CSR 26-2.045)*		34 MoReg 857	35 MoReg 28W	
10 CSR 20-10.050	Clean Water Commission *(Changed to 10 CSR 26-2.050)*		34 MoReg 858	35 MoReg 28W	
10 CSR 20-10.051	Clean Water Commission *(Changed to 10 CSR 26-2.051)*		34 MoReg 862	35 MoReg 29W	
10 CSR 20-10.052	Clean Water Commission *(Changed to 10 CSR 26-2.052)*		34 MoReg 862	35 MoReg 29W	
10 CSR 20-10.053	Clean Water Commission *(Changed to 10 CSR 26-2.053)*		34 MoReg 863	35 MoReg 29W	
10 CSR 20-10.060	Clean Water Commission *(Changed to 10 CSR 26-2.070)*		34 MoReg 866	35 MoReg 29W	
10 CSR 20-10.061	Clean Water Commission *(Changed to 10 CSR 26-2.071)*		34 MoReg 866	35 MoReg 30W	
10 CSR 20-10.062	Clean Water Commission *(Changed to 10 CSR 26-2.072)*		34 MoReg 871	35 MoReg 30W	
10 CSR 20-10.063	Clean Water Commission *(Changed to 10 CSR 26-2.073)*		34 MoReg 877	35 MoReg 31W	
10 CSR 20-10.064	Clean Water Commission *(Changed to 10 CSR 26-2.074)*		34 MoReg 877	35 MoReg 31W	
10 CSR 20-10.065	Clean Water Commission		34 MoReg 884R	35 MoReg 32W	
10 CSR 20-10.066	Clean Water Commission		34 MoReg 884R	35 MoReg 32W	
10 CSR 20-10.067	Clean Water Commission		34 MoReg 884R	35 MoReg 32W	
10 CSR 20-10.068	Clean Water Commission		34 MoReg 885R	35 MoReg 32W	
10 CSR 20-10.070	Clean Water Commission *(Changed to 10 CSR 26-2.060)*		34 MoReg 885	35 MoReg 32W	
10 CSR 20-10.071	Clean Water Commission *(Changed to 10 CSR 26-2.061)*		34 MoReg 885	35 MoReg 33W	
10 CSR 20-10.072	Clean Water Commission *(Changed to 10 CSR 26-2.062)*		34 MoReg 886	35 MoReg 33W	
10 CSR 20-10.073	Clean Water Commission *(Changed to 10 CSR 26-2.063)*		34 MoReg 890	35 MoReg 33W	
10 CSR 20-10.074	Clean Water Commission *(Changed to 10 CSR 26-2.064)*		34 MoReg 890	35 MoReg 34W	
10 CSR 20-11.090	Clean Water Commission *(Changed to 10 CSR 26-3.090)*		34 MoReg 890	35 MoReg 34W	
10 CSR 20-11.091	Clean Water Commission *(Changed to 10 CSR 26-3.091)*		34 MoReg 891	35 MoReg 34W	
10 CSR 20-11.092	Clean Water Commission *(Changed to 10 CSR 26-3.092)*		34 MoReg 891	35 MoReg 34W	
10 CSR 20-11.093	Clean Water Commission *(Changed to 10 CSR 26-3.093)*		34 MoReg 892	35 MoReg 34W	
10 CSR 20-11.094	Clean Water Commission *(Changed to 10 CSR 26-3.094)*		34 MoReg 892	35 MoReg 35W	
10 CSR 20-11.095	Clean Water Commission *(Changed to 10 CSR 26-3.095)*		34 MoReg 896	35 MoReg 35W	
10 CSR 20-11.096	Clean Water Commission *(Changed to 10 CSR 26-3.096)*		34 MoReg 897	35 MoReg 35W	
10 CSR 20-11.097	Clean Water Commission *(Changed to 10 CSR 26-3.097)*		34 MoReg 900	35 MoReg 35W	
10 CSR 20-11.098	Clean Water Commission *(Changed to 10 CSR 26-3.098)*		34 MoReg 903	35 MoReg 35W	
10 CSR 20-11.099	Clean Water Commission *(Changed to 10 CSR 26-3.099)*		34 MoReg 906	35 MoReg 36W	
10 CSR 20-11.101	Clean Water Commission *(Changed to 10 CSR 26-3.101)*		34 MoReg 908	35 MoReg 36W	
10 CSR 20-11.102	Clean Water Commission *(Changed to 10 CSR 26-3.102)*		34 MoReg 908	35 MoReg 36W	
10 CSR 20-11.103	Clean Water Commission *(Changed to 10 CSR 26-3.103)*		34 MoReg 909	35 MoReg 36W	
10 CSR 20-11.104	Clean Water Commission *(Changed to 10 CSR 26-3.104)*		34 MoReg 914	35 MoReg 36W	
10 CSR 20-11.105	Clean Water Commission *(Changed to 10 CSR 26-3.105)*		34 MoReg 914	35 MoReg 37W	
10 CSR 20-11.106	Clean Water Commission *(Changed to 10 CSR 26-3.106)*		34 MoReg 915	35 MoReg 37W	
10 CSR 20-11.107	Clean Water Commission *(Changed to 10 CSR 26-3.107)*		34 MoReg 915	35 MoReg 37W	
10 CSR 20-11.108	Clean Water Commission *(Changed to 10 CSR 26-3.108)*		34 MoReg 918	35 MoReg 37W	
10 CSR 20-11.109	Clean Water Commission *(Changed to 10 CSR 26-3.109)*		34 MoReg 920	35 MoReg 37W	

Rule Number	Agency	Emergency	Proposed	Order	In Addition
10 CSR 20-11.110	Clean Water Commission *(Changed to 10 CSR 26-3.110)*		34 MoReg 920	35 MoReg 37W	
10 CSR 20-11.111	Clean Water Commission *(Changed to 10 CSR 26-3.111)*		34 MoReg 921	35 MoReg 38W	
10 CSR 20-11.112	Clean Water Commission *(Changed to 10 CSR 26-3.112)*		34 MoReg 921	35 MoReg 38W	
10 CSR 20-11.113	Clean Water Commission *(Changed to 10 CSR 26-3.113)*		34 MoReg 925	35 MoReg 38W	
10 CSR 20-11.114	Clean Water Commission *(Changed to 10 CSR 26-3.114)*		34 MoReg 928	35 MoReg 38W	
10 CSR 20-11.115	Clean Water Commission *(Changed to 10 CSR 26-3.115)*		34 MoReg 935	35 MoReg 38W	
10 CSR 20-13.080	Clean Water Commission *(Changed to 10 CSR 26-4.080)*		34 MoReg 937	35 MoReg 39W	
10 CSR 20-15.010	Clean Water Commission *(Changed to 10 CSR 26-5.010)*		34 MoReg 937		
10 CSR 20-15.020	Clean Water Commission *(Changed to 10 CSR 26-5.020)*		34 MoReg 938		
10 CSR 20-15.030	Clean Water Commission *(Changed to 10 CSR 26-5.030)*		34 MoReg 938		
10 CSR 25-19.010	Hazardous Waste Management Commission	34 MoReg 1535	34 MoReg 1553		
10 CSR 26-1.010	Petroleum and Hazardous Substance Storage Tanks		34 MoReg 939	35 MoReg 39W	
10 CSR 26-2.010	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.010)*		34 MoReg 843	35 MoReg 23W	
10 CSR 26-2.011	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.011)*		34 MoReg 845	35 MoReg 24W	
10 CSR 26-2.012	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.012)*		34 MoReg 845	35 MoReg 24W	
10 CSR 26-2.020	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.020)*		34 MoReg 847	35 MoReg 25W	
10 CSR 26-2.021	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.021)*		34 MoReg 849	35 MoReg 25W	
10 CSR 26-2.022	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.022)*		34 MoReg 849	35 MoReg 26W	
10 CSR 26-2.030	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.030)*		34 MoReg 850	35 MoReg 26W	
10 CSR 26-2.031	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.031)*		34 MoReg 851	35 MoReg 26W	
10 CSR 26-2.032	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.032)*		34 MoReg 851	35 MoReg 26W	
10 CSR 26-2.033	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.033)*		34 MoReg 851	35 MoReg 26W	
10 CSR 26-2.034	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.034)*		34 MoReg 852	35 MoReg 27W	
10 CSR 26-2.040	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.040)*		34 MoReg 853	35 MoReg 27W	
10 CSR 26-2.041	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.041)*		34 MoReg 854	35 MoReg 27W	
10 CSR 26-2.042	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.042)*		34 MoReg 854	35 MoReg 27W	
10 CSR 26-2.043	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.043)*		34 MoReg 855	35 MoReg 28W	
10 CSR 26-2.044	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.044)*		34 MoReg 857	35 MoReg 28W	
10 CSR 26-2.045	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.045)*		34 MoReg 857	35 MoReg 28W	
10 CSR 26-2.050	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.050)*		34 MoReg 858	35 MoReg 28W	
10 CSR 26-2.051	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.051)*		34 MoReg 862	35 MoReg 29W	
10 CSR 26-2.052	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.052)*		34 MoReg 862	35 MoReg 29W	
10 CSR 26-2.053	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.053)*		34 MoReg 863	35 MoReg 29W	
10 CSR 26-2.060	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.070)*		34 MoReg 885	35 MoReg 32W	
10 CSR 26-2.061	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.071)*		34 MoReg 885	35 MoReg 33W	
10 CSR 26-2.062	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.072)*		34 MoReg 886	35 MoReg 33W	
10 CSR 26-2.063	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.073)*		34 MoReg 890	35 MoReg 33W	
10 CSR 26-2.064	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.074)*		34 MoReg 890	35 MoReg 34W	
10 CSR 26-2.070	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.060)*		34 MoReg 866	35 MoReg 29W	
10 CSR 26-2.071	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.061)*		34 MoReg 866	35 MoReg 30W	
10 CSR 26-2.072	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.062)*		34 MoReg 871	35 MoReg 30W	

Rule Number	Agency	Emergency	Proposed	Order	In Addition
10 CSR 26-2.073	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.063)*		34 MoReg 877	35 MoReg 31W	
10 CSR 26-2.074	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.064)*		34 MoReg 877	35 MoReg 31W	
10 CSR 26-2.075	Petroleum and Hazardous Substance Storage Tanks		34 MoReg 939	35 MoReg 39W	
10 CSR 26-2.076	Petroleum and Hazardous Substance Storage Tanks		34 MoReg 956	35 MoReg 41W	
10 CSR 26-2.077	Petroleum and Hazardous Substance Storage Tanks		34 MoReg 968	35 MoReg 44W	
10 CSR 26-2.078	Petroleum and Hazardous Substance Storage Tanks		34 MoReg 978	35 MoReg 45W	
10 CSR 26-2.079	Petroleum and Hazardous Substance Storage Tanks		34 MoReg 991	35 MoReg 45W	
10 CSR 26-2.080	Petroleum and Hazardous Substance Storage Tanks		34 MoReg 1004	35 MoReg 48W	
10 CSR 26-2.081	Petroleum and Hazardous Substance Storage Tanks		34 MoReg 1009	35 MoReg 49W	
10 CSR 26-2.082	Petroleum and Hazardous Substance Storage Tanks		34 MoReg 1020	35 MoReg 53W	
10 CSR 26-3.090	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.090)*		34 MoReg 890	35 MoReg 34W	
10 CSR 26-3.091	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.091)*		34 MoReg 891	35 MoReg 34W	
10 CSR 26-3.092	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.092)*		34 MoReg 891	35 MoReg 34W	
10 CSR 26-3.093	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.093)*		34 MoReg 892	35 MoReg 34W	
10 CSR 26-3.094	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.094)*		34 MoReg 892	35 MoReg 35W	
10 CSR 26-3.095	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.095)*		34 MoReg 896	35 MoReg 35W	
10 CSR 26-3.096	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.096)*		34 MoReg 897	35 MoReg 35W	
10 CSR 26-3.097	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.097)*		34 MoReg 900	35 MoReg 35W	
10 CSR 26-3.098	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.098)*		34 MoReg 903	35 MoReg 35W	
10 CSR 26-3.099	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.099)*		34 MoReg 906	35 MoReg 36W	
10 CSR 26-3.101	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.101)*		34 MoReg 908	35 MoReg 36W	
10 CSR 26-3.102	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.102)*		34 MoReg 908	35 MoReg 36W	
10 CSR 26-3.103	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.103)*		34 MoReg 909	35 MoReg 36W	
10 CSR 26-3.104	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.104)*		34 MoReg 914	35 MoReg 36W	
10 CSR 26-3.105	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.105)*		34 MoReg 914	35 MoReg 37W	
10 CSR 26-3.106	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.106)*		34 MoReg 915	35 MoReg 37W	
10 CSR 26-3.107	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.107)*		34 MoReg 915	35 MoReg 37W	
10 CSR 26-3.108	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.108)*		34 MoReg 918	35 MoReg 37W	
10 CSR 26-3.109	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.109)*		34 MoReg 920	35 MoReg 37W	
10 CSR 26-3.110	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.110)*		34 MoReg 920	35 MoReg 37W	
10 CSR 26-3.111	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.111)*		34 MoReg 921	35 MoReg 38W	
10 CSR 26-3.112	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.112)*		34 MoReg 921	35 MoReg 38W	
10 CSR 26-3.113	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.113)*		34 MoReg 925	35 MoReg 38W	
10 CSR 26-3.114	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.114)*		34 MoReg 928	35 MoReg 38W	
10 CSR 26-3.115	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.115)*		34 MoReg 935	35 MoReg 38W	
10 CSR 26-4.080	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-13.080)*		34 MoReg 937	35 MoReg 39W	
10 CSR 26-5.010	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-15.010)*		34 MoReg 937		
10 CSR 26-5.020	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-15.020)*		34 MoReg 938		
10 CSR 26-5.030	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-15.030)*		34 MoReg 938		
10 CSR 60-13.020	Safe Drinking Water Commission	34 MoReg 1393	34 MoReg 1561	34 MoReg 2602	
10 CSR 70-4.010	Soil and Water Districts Commission		This IssueR This Issue		
10 CSR 70-5.010	Soil and Water Districts Commission	34 MoReg 1779	This IssueR This Issue		
10 CSR 70-5.020	Soil and Water Districts Commission	34 MoReg 1780			
10 CSR 70-5.030	Soil and Water Districts Commission	34 MoReg 1782			

Rule Number	Agency	Emergency	Proposed	Order	In Addition
10 CSR 70-5.040	Soil and Water Districts Commission	34 MoReg 1783	This IssueR This Issue		
10 CSR 70-5.050	Soil and Water Districts Commission	34 MoReg 1785	This IssueR This Issue		
10 CSR 70-5.060	Soil and Water Districts Commission	34 MoReg 1786	This IssueR This Issue		
	DEPARTMENT OF PUBLIC SAFETY				
11 CSR 40-2.010	Division of Fire Safety		34 MoReg 1570	35 MoReg 53	
11 CSR 40-2.015	Division of Fire Safety		34 MoReg 1572	35 MoReg 53	
11 CSR 40-2.022	Division of Fire Safety		34 MoReg 1573	35 MoReg 54	
11 CSR 40-2.030	Division of Fire Safety		34 MoReg 1574	35 MoReg 54	
11 CSR 40-2.040	Division of Fire Safety		34 MoReg 1575	35 MoReg 55	
11 CSR 40-2.061	Division of Fire Safety		34 MoReg 1578	35 MoReg 56	
11 CSR 45-4.020	Missouri Gaming Commission		34 MoReg 1797		
11 CSR 45-4.190	Missouri Gaming Commission		34 MoReg 1797		
11 CSR 45-4.200	Missouri Gaming Commission		34 MoReg 1797		
11 CSR 45-4.500	Missouri Gaming Commission		34 MoReg 1798		
11 CSR 45-4.510	Missouri Gaming Commission		34 MoReg 1798		
11 CSR 45-4.520	Missouri Gaming Commission		34 MoReg 1801		
11 CSR 45-4.530	Missouri Gaming Commission		34 MoReg 1801		
11 CSR 45-4.540	Missouri Gaming Commission		34 MoReg 1802		
11 CSR 45-5.100	Missouri Gaming Commission		34 MoReg 1578	34 MoReg 2602	
11 CSR 45-10.040	Missouri Gaming Commission		35 MoReg 99		
11 CSR 45-11.020	Missouri Gaming Commission	35 MoReg 85	35 MoReg 100		
11 CSR 45-11.030	Missouri Gaming Commission	35 MoReg 86	35 MoReg 103		
11 CSR 45-11.050	Missouri Gaming Commission	35 MoReg 86	35 MoReg 103		
11 CSR 45-11.070	Missouri Gaming Commission	35 MoReg 87	35 MoReg 103		
11 CSR 45-11.130	Missouri Gaming Commission	35 MoReg 88	35 MoReg 104		
11 CSR 50-2.320	Missouri State Highway Patrol		34 MoReg 1990	35 MoReg 56	
	DEPARTMENT OF REVENUE				
12 CSR 10-2.045	Director of Revenue		35 MoReg 13		
12 CSR 10-3.562	Director of Revenue		34 MoReg 1729R	34 MoReg 2549R	
12 CSR 10-41.010	Director of Revenue	34 MoReg 2528	34 MoReg 2536		
12 CSR 10-110.900	Director of Revenue		34 MoReg 2467		
12 CSR 30-3.010	State Tax Commission		This Issue		
12 CSR 30-3.025	State Tax Commission		This Issue		
12 CSR 30-4.010	State Tax Commission		This Issue		
	DEPARTMENT OF SOCIAL SERVICES				
13 CSR 70-3.030	MO HealthNet Division		34 MoReg 1990	35 MoReg 56	
13 CSR 70-3.100	MO HealthNet Division		34 MoReg 1993	35 MoReg 56	
13 CSR 70-3.170	MO HealthNet Division	34 MoReg 1537	34 MoReg 1578	34 MoReg 2549	
13 CSR 70-10.016	MO HealthNet Division	34 MoReg 2583	34 MoReg 1582	34 MoReg 2602	
13 CSR 70-10.110	MO HealthNet Division	34 MoReg 2585 35 MoReg 5	34 MoReg 1586 35 MoReg 13	34 MoReg 2603	
13 CSR 70-15.010	MO HealthNet Division	This Issue	34 MoReg 1802	This Issue	
13 CSR 70-15.110	MO HealthNet Division	34 MoReg 1538 35 MoReg 5	34 MoReg 1588 35 MoReg 17	34 MoReg 2603	
13 CSR 70-20.034	MO HealthNet Division		34 MoReg 1994	35 MoReg 56	
13 CSR 70-20.320	MO HealthNet Division	35 MoReg 6	34 MoReg 1590 35 MoReg 19	34 MoReg 2603	
13 CSR 70-35.010	MO HealthNet Division		34 MoReg 1994	35 MoReg 56	
13 CSR 70-40.010	MO HealthNet Division		34 MoReg 1996	35 MoReg 57	
13 CSR 70-90.010	MO HealthNet Division		34 MoReg 1998	35 MoReg 57	
13 CSR 70-90.020	MO HealthNet Division		34 MoReg 2000	35 MoReg 57	
13 CSR 70-95.010	MO HealthNet Division		34 MoReg 2000	35 MoReg 57	
	ELECTED OFFICIALS				
15 CSR 30-45.040	Secretary of State		34 MoReg 1488		
15 CSR 40-4.010	State Auditor		This Issue		
15 CSR 40-4.020	State Auditor		This Issue		
15 CSR 40-4.030	State Auditor		This Issue		
15 CSR 40-4.040	State Auditor		This Issue		
15 CSR 50-2.050	Treasurer	34 MoReg 2528	34 MoReg 2540		
	RETIREMENT SYSTEMS				
16 CSR 10-5.010	The Public School Retirement System of Missouri		This Issue		
16 CSR 10-5.020	The Public School Retirement System of Missouri		This Issue		
16 CSR 10-6.060	The Public School Retirement System of Missouri		This Issue		
16 CSR 10-6.070	The Public School Retirement System of Missouri		This Issue		
16 CSR 20-2.080	Missouri Local Government Employees' Retirement System (LAGERS)		35 MoReg 104R 35 MoReg 105		
16 CSR 20-2.105	Missouri Local Government Employees' Retirement System (LAGERS)		34 MoReg 2595		
16 CSR 50-2.035	The County Employees' Retirement Fund		34 MoReg 2146	This Issue	
	DEPARTMENT OF HEALTH AND SENIOR SERVICES				
19 CSR 20-28	Division of Community and Public Health				34 MoReg 2432

Rule Number	Agency	Emergency	Proposed	Order	In Addition
19 CSR 30-40.342	Division of Regulation and Licensure		34 MoReg 2147		
19 CSR 30-70.650	Division of Regulation and Licensure		34 MoReg 1729	35 MoReg 119	
19 CSR 60-50	Missouri Health Facilities Review Committee				35 MoReg 126 This Issue
	DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION				
20 CSR	Construction Claims Binding Arbitration Cap				33 MoReg 150 33 MoReg 2446
20 CSR	Medical Malpractice				31 MoReg 616 32 MoReg 545
20 CSR	Sovereign Immunity Limits				31 MoReg 2019 33 MoReg 150 33 MoReg 2446 This Issue
20 CSR	State Legal Expense Fund Cap				32 MoReg 668 33 MoReg 150 33 MoReg 2446
20 CSR 200-1.005	Insurance Solvency and Company Regulation		34 MoReg 1738	35 MoReg 57	
20 CSR 200-1.030	Insurance Solvency and Company Regulation		34 MoReg 1738	35 MoReg 58	
20 CSR 200-1.105	Insurance Solvency and Company Regulation		34 MoReg 2154	This Issue	
20 CSR 400-3.650	Life, Annuities and Health	34 MoReg 1539	34 MoReg 1805	This Issue	
20 CSR 1105-3.011	Credit Union Commission		34 MoReg 2472		
20 CSR 1105-3.012	Credit Union Commission		34 MoReg 2472		
20 CSR 2015-1.030	Acupuncturist Advisory Committee	34 MoReg 1173			
20 CSR 2030-2.040	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		34 MoReg 1921	34 MoReg 2603	
20 CSR 2030-21.010	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		34 MoReg 1921	34 MoReg 2603	
20 CSR 2070-2.031	State Board of Chiropractic Examiners		34 MoReg 2154	35 MoReg 120	
20 CSR 2070-2.080	State Board of Chiropractic Examiners		34 MoReg 2159	35 MoReg 120	
20 CSR 2070-2.081	State Board of Chiropractic Examiners		34 MoReg 2164	35 MoReg 120	
20 CSR 2070-2.090	State Board of Chiropractic Examiners		34 MoReg 2168	35 MoReg 120	
20 CSR 2070-4.010	State Board of Chiropractic Examiners		34 MoReg 2168R 34 MoReg 2168	35 MoReg 120R 35 MoReg 121	
20 CSR 2070-4.020	State Board of Chiropractic Examiners		34 MoReg 2174R	35 MoReg 121R	
20 CSR 2070-4.030	State Board of Chiropractic Examiners		34 MoReg 2174R	35 MoReg 121R	
20 CSR 2085-3.010	Board of Cosmetology and Barber Examiners	34 MoReg 1459	34 MoReg 1024 34 MoReg 1921	34 MoReg 1743 34 MoReg 2604	
20 CSR 2085-9.020	Board of Cosmetology and Barber Examiners		34 MoReg 1925	34 MoReg 2604	
20 CSR 2085-12.040	Board of Cosmetology and Barber Examiners		34 MoReg 1928	34 MoReg 2604	
20 CSR 2085-12.070	Board of Cosmetology and Barber Examiners		34 MoReg 1928	34 MoReg 2604	
20 CSR 2085-12.080	Board of Cosmetology and Barber Examiners		34 MoReg 1928	34 MoReg 2604	
20 CSR 2120-1.040	State Board of Embalmers and Funeral Directors		34 MoReg 1929	34 MoReg 2605	
20 CSR 2120-2.010	State Board of Embalmers and Funeral Directors		34 MoReg 1929	34 MoReg 2605	
20 CSR 2120-2.040	State Board of Embalmers and Funeral Directors		34 MoReg 1930	34 MoReg 2605	
20 CSR 2120-2.060	State Board of Embalmers and Funeral Directors		34 MoReg 1930	34 MoReg 2605	
20 CSR 2120-2.100	State Board of Embalmers and Funeral Directors	34 MoReg 2357	34 MoReg 2417		
20 CSR 2120-2.130	State Board of Embalmers and Funeral Directors	35 MoReg 88	35 MoReg 105		
20 CSR 2120-2.140	State Board of Embalmers and Funeral Directors	35 MoReg 89	35 MoReg 105		
20 CSR 2120-2.150	State Board of Embalmers and Funeral Directors	35 MoReg 90	35 MoReg 106		
20 CSR 2120-3.100	State Board of Embalmers and Funeral Directors	34 MoReg 2463			
20 CSR 2120-3.105	State Board of Embalmers and Funeral Directors	34 MoReg 2357	34 MoReg 2421		
20 CSR 2120-3.115	State Board of Embalmers and Funeral Directors	35 MoReg 90	35 MoReg 106		
20 CSR 2120-3.120	State Board of Embalmers and Funeral Directors	35 MoReg 91	35 MoReg 109		
20 CSR 2120-3.125	State Board of Embalmers and Funeral Directors	34 MoReg 2358	34 MoReg 2424		
20 CSR 2120-3.200	State Board of Embalmers and Funeral Directors	35 MoReg 92	35 MoReg 109		
20 CSR 2120-3.300	State Board of Embalmers and Funeral Directors	35 MoReg 92	35 MoReg 109		
20 CSR 2120-3.305	State Board of Embalmers and Funeral Directors	35 MoReg 93	35 MoReg 110		
20 CSR 2120-3.310	State Board of Embalmers and Funeral Directors	35 MoReg 93	35 MoReg 110		
20 CSR 2120-3.400	State Board of Embalmers and Funeral Directors	35 MoReg 94	35 MoReg 112		
20 CSR 2120-3.405	State Board of Embalmers and Funeral Directors	34 MoReg 2464	34 MoReg 2424		
20 CSR 2120-3.410	State Board of Embalmers and Funeral Directors	35 MoReg 95	35 MoReg 112		
20 CSR 2120-3.505	State Board of Embalmers and Funeral Directors	35 MoReg 95	35 MoReg 112		
20 CSR 2120-3.515	State Board of Embalmers and Funeral Directors	35 MoReg 96	35 MoReg 113		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
20 CSR 2120-3.525	State Board of Embalmers and Funeral Directors	35 MoReg 97	35 MoReg 113		
20 CSR 2145-2.030	Missouri Board of Geologist Registration		34 MoReg 2174	35 MoReg 121	
20 CSR 2145-2.040	Missouri Board of Geologist Registration		34 MoReg 2175	35 MoReg 121	
20 CSR 2150-2.100	State Board of Registration for the Healing Arts		34 MoReg 2175	35 MoReg 121	
20 CSR 2150-2.155	State Board of Registration for the Healing Arts		34 MoReg 2175	35 MoReg 122	
20 CSR 2150-3.203	State Board of Registration for the Healing Arts		34 MoReg 2179	35 MoReg 122	
20 CSR 2150-4.053	State Board of Registration for the Healing Arts		34 MoReg 2179	35 MoReg 122	
20 CSR 2150-5.020	State Board of Registration for the Healing Arts		34 MoReg 2001	34 MoReg 2605	
20 CSR 2150-5.025	State Board of Registration for the Healing Arts	34 MoReg 2529	34 MoReg 2540		
20 CSR 2197-2.030	Board of Therapeutic Massage		34 MoReg 2180	35 MoReg 122	
20 CSR 2197-4.010	Board of Therapeutic Massage		34 MoReg 2180R 34 MoReg 2180	35 MoReg 122R 35 MoReg 122	
20 CSR 2197-4.030	Board of Therapeutic Massage		34 MoReg 2185	35 MoReg 123	
20 CSR 2197-4.040	Board of Therapeutic Massage		34 MoReg 2190	35 MoReg 123	
20 CSR 2200-4.020	State Board of Nursing		34 MoReg 2192	35 MoReg 123	
20 CSR 2200-4.021	State Board of Nursing		34 MoReg 2473R		
20 CSR 2200-4.022	State Board of Nursing		34 MoReg 2473		
20 CSR 2205-1.050	Missouri Board of Occupational Therapy	34 MoReg 1173			
20 CSR 2220-2.175	State Board of Pharmacy		34 MoReg 2195	This Issue	
20 CSR 2220-2.700	State Board of Pharmacy		34 MoReg 2204	This Issue	
20 CSR 2220-6.050	State Board of Pharmacy	34 MoReg 2531	34 MoReg 2542		
20 CSR 2220-6.055	State Board of Pharmacy	34 MoReg 2534	34 MoReg 2544		
20 CSR 2232-2.040	Missouri State Committee of Interpreters		34 MoReg 2204	35 MoReg 123	
20 CSR 2234-1.010	Board of Private Investigator Examiners		34 MoReg 1593	34 MoReg 2605	
20 CSR 2234-1.020	Board of Private Investigator Examiners		34 MoReg 1594	34 MoReg 2606	
20 CSR 2234-1.030	Board of Private Investigator Examiners		34 MoReg 1597	34 MoReg 2606	
20 CSR 2234-1.040	Board of Private Investigator Examiners		34 MoReg 1600	34 MoReg 2606	
20 CSR 2234-1.050	Board of Private Investigator Examiners		34 MoReg 1603	34 MoReg 2606	
20 CSR 2234-2.010	Board of Private Investigator Examiners		34 MoReg 1603	34 MoReg 2607	
20 CSR 2234-2.020	Board of Private Investigator Examiners		34 MoReg 1609	34 MoReg 2608	
20 CSR 2234-2.030	Board of Private Investigator Examiners		34 MoReg 1613	34 MoReg 2608	
20 CSR 2234-2.040	Board of Private Investigator Examiners		34 MoReg 1617	34 MoReg 2608	
20 CSR 2234-3.010	Board of Private Investigator Examiners		34 MoReg 1621	34 MoReg 2608	
20 CSR 2234-3.020	Board of Private Investigator Examiners		34 MoReg 1626	34 MoReg 2610	
20 CSR 2234-3.030	Board of Private Investigator Examiners		34 MoReg 1630	34 MoReg 2610	
20 CSR 2234-3.040	Board of Private Investigator Examiners		34 MoReg 1634	34 MoReg 2610	
20 CSR 2234-3.050	Board of Private Investigator Examiners		34 MoReg 1639	34 MoReg 2610	
20 CSR 2234-3.060	Board of Private Investigator Examiners		34 MoReg 1641	34 MoReg 2610	
20 CSR 2234-3.070	Board of Private Investigator Examiners		34 MoReg 1643	34 MoReg 2611	
20 CSR 2234-4.010	Board of Private Investigator Examiners		34 MoReg 1645	34 MoReg 2611	
20 CSR 2234-4.020	Board of Private Investigator Examiners		34 MoReg 1650	34 MoReg 2611	
20 CSR 2234-4.030	Board of Private Investigator Examiners		34 MoReg 1653	34 MoReg 2611	
20 CSR 2234-4.040	Board of Private Investigator Examiners		34 MoReg 1657	34 MoReg 2611	
20 CSR 2234-4.050	Board of Private Investigator Examiners		34 MoReg 1661	34 MoReg 2612	
20 CSR 2234-5.010	Board of Private Investigator Examiners		34 MoReg 1665	34 MoReg 2612	
20 CSR 2234-6.010	Board of Private Investigator Examiners		34 MoReg 1668	34 MoReg 2612	
20 CSR 2234-7.010	Board of Private Investigator Examiners		34 MoReg 1674	34 MoReg 2612	
20 CSR 2245-1.010	Real Estate Appraisers		34 MoReg 2207	35 MoReg 123	
20 CSR 2245-3.005	Real Estate Appraisers		34 MoReg 2207	35 MoReg 123	
20 CSR 2245-3.010	Real Estate Appraisers		34 MoReg 2207	This Issue	
20 CSR 2245-4.050	Real Estate Appraisers		34 MoReg 2208	This IssueW	
20 CSR 2245-4.060	Real Estate Appraisers		34 MoReg 2208	This IssueW	
20 CSR 2245-5.020	Real Estate Appraisers		34 MoReg 2209	35 MoReg 124	
20 CSR 2245-6.015	Real Estate Appraisers		34 MoReg 2213	This IssueW	
20 CSR 2245-6.040	Real Estate Appraisers		34 MoReg 2213	35 MoReg 124	
20 CSR 2245-8.010	Real Estate Appraisers		34 MoReg 2213	35 MoReg 124	
20 CSR 2245-8.030	Real Estate Appraisers		34 MoReg 2214	35 MoReg 124	
20 CSR 2250-3.010	Missouri Real Estate Commission		34 MoReg 2214	35 MoReg 124	
20 CSR 2250-4.020	Missouri Real Estate Commission		34 MoReg 2218	35 MoReg 125	
20 CSR 2250-9.020	Missouri Real Estate Commission		34 MoReg 2221	35 MoReg 125	
20 CSR 2263-1.010	State Committee for Social Workers		34 MoReg 2221R 34 MoReg 2221		
20 CSR 2263-1.035	State Committee for Social Workers		34 MoReg 2222		
20 CSR 2263-2.020	State Committee for Social Workers		34 MoReg 2225R 34 MoReg 2225		
20 CSR 2263-2.022	State Committee for Social Workers		34 MoReg 2225R		
20 CSR 2263-2.030	State Committee for Social Workers		34 MoReg 2226		
20 CSR 2263-2.031	State Committee for Social Workers		34 MoReg 2226R 34 MoReg 2226		
20 CSR 2263-2.032	State Committee for Social Workers		34 MoReg 2233		
20 CSR 2263-2.045	State Committee for Social Workers		34 MoReg 2238		
20 CSR 2263-2.047	State Committee for Social Workers		34 MoReg 2242R		
20 CSR 2263-2.050	State Committee for Social Workers		34 MoReg 2242		
20 CSR 2263-2.052	State Committee for Social Workers		34 MoReg 2248R		
20 CSR 2263-2.060	State Committee for Social Workers		34 MoReg 2248		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
20 CSR 2263-2.062	State Committee for Social Workers		34 MoReg 2248R		
20 CSR 2263-2.070	State Committee for Social Workers		34 MoReg 2249R 34 MoReg 2249		
20 CSR 2263-2.072	State Committee for Social Workers		34 MoReg 2253R		
20 CSR 2263-2.075	State Committee for Social Workers		34 MoReg 2253		
20 CSR 2263-2.082	State Committee for Social Workers		34 MoReg 2253		
20 CSR 2263-2.085	State Committee for Social Workers		34 MoReg 2255R 34 MoReg 2255		
20 CSR 2263-2.090	State Committee for Social Workers		34 MoReg 2261		
20 CSR 2263-3.010	State Committee for Social Workers		34 MoReg 2263R 34 MoReg 2263		
20 CSR 2263-3.020	State Committee for Social Workers		34 MoReg 2263R 34 MoReg 2263		
20 CSR 2263-3.040	State Committee for Social Workers		34 MoReg 2264R 34 MoReg 2264		
20 CSR 2263-3.060	State Committee for Social Workers		34 MoReg 2265R 34 MoReg 2266		
20 CSR 2263-3.080	State Committee for Social Workers		34 MoReg 2266R 34 MoReg 2267		
20 CSR 2263-3.100	State Committee for Social Workers		34 MoReg 2267R 34 MoReg 2267		
20 CSR 2263-3.120	State Committee for Social Workers		34 MoReg 2268R 34 MoReg 2268		
20 CSR 2263-3.140	State Committee for Social Workers		34 MoReg 2269R 34 MoReg 2269		
20 CSR 2267-2.010	Office of Tattooing, Body Piercing, and Branding		34 MoReg 1932	34 MoReg 2613	
20 CSR 2267-2.020	Office of Tattooing, Body Piercing, and Branding	34 MoReg 1174			
20 CSR 2267-6.030	Office of Tattooing, Body Piercing, and Branding		34 MoReg 1937R	34 MoReg 2614R	
20 CSR 2270-4.042	Missouri Veterinary Medical Board		34 MoReg 1937	34 MoReg 2614	
	MISSOURI CONSOLIDATED HEALTH CARE PLAN				
22 CSR 10-2.010	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.020	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.045	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.050	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.051	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.053	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.054	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.055	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.060	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.064	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.067	Health Care Plan	This IssueR	This IssueR		
22 CSR 10-2.090	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.010	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.020	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.030	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.045	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.050	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.051	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.052	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.053	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.054	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.055	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.060	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.090	Health Care Plan	This Issue	This Issue		

Agency		Publication	Effective	Expiration
Department of Agriculture				
Missouri Agricultural and Small Business Development Authority				
2 CSR 100-6.010	Description of Operation, Definitions, Fee Structures, Applicant Requirements, and Procedures for Making and Collecting Loans and Amending the Rules for the Single-Purpose Animal Facilities Loan Guarantee Program	34 MoReg 2527	Nov.. 2, 2009	April 30, 2010
Department of Economic Development				
Division of Business and Community Services				
4 CSR 85-6.010	Recovery Zone Bond Allocation, Waiver, and Reallocation	34 MoReg 2353	Sept. 28, 2009	March 26, 2010
Department of Higher Education				
University of Missouri				
6 CSR 250-11.041	Inspection Fee on Manipulated Animal or Vegetable Manure Fertilizers	This Issue	Jan. 1, 2010	June 28, 2010
Department of Natural Resources				
Clean Water Commission				
10 CSR 20-4.040	State Revolving Fund General Assistance Regulation	34 MoReg 1326	May 22, 2009	Feb. 25, 2010
Hazardous Waste Management Commission				
10 CSR 25-19.010	Electronics Scrap Management	34 MoReg 1535	July 1, 2009	Feb. 25, 2010
Safe Drinking Water Commission				
10 CSR 60-13.020	Drinking Water Revolving Fund Loan Program	34 MoReg 1393	May 30, 2009	Feb. 25, 2010
Soil and Water Districts Commission				
10 CSR 70-5.010	Apportionment of Funds	34 MoReg 1779	Aug. 8, 2009	Feb. 25, 2010
10 CSR 70-5.020	Application and Eligibility for Funds	34 MoReg 1780	Aug. 8, 2009	Feb. 25, 2010
10 CSR 70-5.030	Design, Layout and Construction of Proposed Practices; Operation and Maintenance	34 MoReg 1782	Aug. 8, 2009	Feb. 25, 2010
10 CSR 70-5.040	Rates and Reimbursement Procedures	34 MoReg 1783	Aug. 8, 2009	Feb. 25, 2010
10 CSR 70-5.050	District Administration of the Program	34 MoReg 1785	Aug. 8, 2009	Feb. 25, 2010
10 CSR 70-5.060	Commission Administration of the Program	34 MoReg 1786	Aug. 8, 2009	Feb. 25, 2010
Department of Public Safety				
Missouri Gaming Commission				
11 CSR 45-11.020	Deposit Account—Taxes and Fees	35 MoReg 85	Jan. 6, 2010	July 4, 2010
11 CSR 45-11.030	Payment—Gaming Tax	35 MoReg 86	Jan. 6, 2010	July 4, 2010
11 CSR 45-11.050	Admission Fee	35 MoReg 86	Jan. 6, 2010	July 4, 2010
11 CSR 45-11.070	Return and Payment—Admission Fee	35 MoReg 87	Jan. 6, 2010	July 4, 2010
11 CSR 45-11.130	Failure to File Return or Pay Tax or Fee	35 MoReg 88	Jan. 6, 2010	July 4, 2010
Department of Revenue				
Director of Revenue				
12 CSR 10-41.010	Annual Adjusted Rate of Interest	34 MoReg 2528	Jan. 1, 2010	June 29, 2010
Department of Social Services				
MO HealthNet Division				
13 CSR 70-10.110	Nursing Facility Reimbursement Allowance	35 MoReg 5	Jan. 1, 2010	June 29, 2010
13 CSR 70-15.010	Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology.	This Issue	Jan. 1, 2010	June 29, 2010
13 CSR 70-15.110	Federal Reimbursement Allowance (FRA)	35 MoReg 5	Jan. 1, 2010	June 29, 2010
13 CSR 70-20.320	Pharmacy Reimbursement Allowance	35 MoReg 6	Jan. 1, 2010	June 29, 2010
Elected Officials				
Treasurer				
15 CSR 50-2.050	Interest Rate on Linked Deposit Loans	34 MoReg 2528	Nov. 7, 2009	May 5, 2010

Agency	Publication	Effective	Expiration
Department of Insurance, Financial Institutions and Professional Registration			
Life, Annuities and Health			
20 CSR 400-3.650 Medicare Supplement Insurance Minimum Standards Act	34 MoReg 1539	July. 1, 2009	Feb. 25, 2010
Board of Cosmetology and Barber Examiners			
20 CSR 2085-3.010 Fees	34 MoReg 1459	June 18, 2009	Feb. 25, 2010
State Board of Embalmers and Funeral Directors			
20 CSR 2120-2.100 Fees	34 MoReg 2357	Oct. 4, 2009	April 1, 2010
20 CSR 2120-2.130 Final Disposition as Defined in Chapter 193	35 MoReg 88	Dec. 4, 2009	June 11, 2010
20 CSR 2120-2.140 Financial Welfare Cause for Injunction	35 MoReg 89	Dec. 4, 2009	June 11, 2010
20 CSR 2120-2.150 Payment Not Determining Factor of Practice of Funeral Directing	35 MoReg 90	Dec. 4, 2009	June 11, 2010
20 CSR 2120-3.100 Notice of Intent to Apply	34 MoReg 2463	Nov. 2, 2009	March 5, 2010
20 CSR 2120-3.105 Filing of Annual Reports	34 MoReg 2357	Oct. 4, 2009	April 1, 2010
20 CSR 2120-3.115 Contact Information	35 MoReg 90	Dec. 4, 2009	June 11, 2010
20 CSR 2120-3.120 Display of License	35 MoReg 91	Dec. 4, 2009	June 11, 2010
20 CSR 2120-3.125 Corporate Ownership of a Licensee	34 MoReg 2358	Oct. 4, 2009	April 1, 2010
20 CSR 2120-3.200 Seller Obligations	35 MoReg 92	Dec. 4, 2009	June 11, 2010
20 CSR 2120-3.300 Provider Includes Funeral Establishment	35 MoReg 92	Dec. 4, 2009	June 11, 2010
20 CSR 2120-3.305 Funeral Director Agent Registration	35 MoReg 93	Dec. 4, 2009	June 11, 2010
20 CSR 2120-3.310 Change in Seller Affiliation	35 MoReg 93	Dec. 4, 2009	June 11, 2010
20 CSR 2120-3.400 Preneed Agents—Requirements of Agent's Seller	35 MoReg 94	Dec. 4, 2009	June 11, 2010
20 CSR 2120-3.405 Preneed Agents—Missouri Law Exam	34 MoReg 2464	Nov. 2, 2009	April 1, 2010
20 CSR 2120-3.410 Preneed Agent's Seller Must be Licensed	35 MoReg 95	Dec. 4, 2009	June 11, 2010
20 CSR 2120-3.505 Types of Financing; Other Financing Still Preneed	35 MoReg 95	Dec. 4, 2009	June 11, 2010
20 CSR 2120-3.515 Single Premium Annuity Contracts	35 MoReg 96	Dec. 4, 2009	June 11, 2010
20 CSR 2120-3.525 Independent Financial Advisor is Agent of Trustee	35 MoReg 97	Dec. 4, 2009	June 11, 2010
State Board of Registration for the Healing Arts			
20 CSR 2150-5.025 Administration of Vaccines Per Protocol	34 MoReg 2529	Nov. 1, 2009	April 29, 2010
State Board of Pharmacy			
20 CSR 2220-6.050 Administration of Vaccines Per Protocol	34 MoReg 2531	Nov. 1, 2009	April 29, 2010
20 CSR 2220-6.055 Non-Dispensing Activities	34 MoReg 2534	Nov. 2, 2009	April 30, 2010
Missouri Consolidated Health Care Plan			
Health Care Plan			
22 CSR 10-2.010 Definitions	This Issue	Jan. 1, 2010	June 29, 2010
22 CSR 10-2.020 Subscriber Agreement and General Membership Provisions	This Issue	Jan. 1, 2010	June 29, 2010
22 CSR 10-2.045 Plan Utilization Review Policy	This Issue	Jan. 1, 2010	June 29, 2010
22 CSR 10-2.050 CoPay Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2010	June 29, 2010
22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2010	June 29, 2010
22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2010	June 29, 2010
22 CSR 10-2.054 Medicare Supplement Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2010	June 29, 2010
22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2010	June 29, 2010
22 CSR 10-2.060 PPO 300 Plan, HDHP, Copay, and HMO Plan Limitations	This Issue	Jan. 1, 2010	June 29, 2010
22 CSR 10-2.064 HMO Summary of Medical Benefits	This Issue	Jan. 1, 2010	June 29, 2010
22 CSR 10-2.067 HMO and POS Limitations	This Issue	Jan. 1, 2010	June 29, 2010
22 CSR 10-2.090 Pharmacy Benefit Summary	This Issue	Jan. 1, 2010	June 29, 2010
22 CSR 10-3.010 Definitions	This Issue	Jan. 1, 2010	June 29, 2010
22 CSR 10-3.020 Subscriber Agreement and General Membership Provisions	This Issue	Jan. 1, 2010	June 29, 2010
22 CSR 10-3.030 Public Entity Membership Agreement and Participation Period	This Issue	Jan. 1, 2010	June 29, 2010
22 CSR 10-3.045 Plan Utilization Review Policy	This Issue	Jan. 1, 2010	June 29, 2010
22 CSR 10-3.050 Copay Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2010	June 29, 2010
22 CSR 10-3.051 PPO 300 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2010	June 29, 2010
22 CSR 10-3.052 PPO 500 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2010	June 29, 2010
22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2010	June 29, 2010
22 CSR 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2010	June 29, 2010
22 CSR 10-3.055 High Deductible Health Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2010	June 29, 2010
22 CSR 10-3.060 PPO 300 Plan, PPO 500 Plan, PPO 1000 Plan, PPO 2000 Plan, HDHP, and Copay Plan Limitations	This Issue	Jan. 1, 2010	June 29, 2010
22 CSR 10-3.090 Pharmacy Benefit Summary	This Issue	Jan. 1, 2010	June 29, 2010

Executive Orders	Subject Matter	Filed Date	Publication
	2010		
10-13	Directs the Department of Social Services to disband the Missouri Task Force on Youth Aging Out of Foster Care	Jan. 15, 2010	Next Issue
10-12	Rescinds Executive Orders 98-14, 95-21, 95-17, and 94-19 and terminates the Governor's Commission on Driving While Intoxicated and Impaired Driving	Jan. 15, 2010	Next Issue
10-11	Rescinds Executive Order 05-41 and terminates the Governor's Advisory Council for Veterans Affairs and assigns its duties to the Missouri Veterans Commission	Jan. 15, 2010	Next Issue
10-10	Rescinds Executive Order 01-08 and terminates the Personal Independence Commission and assigns its duties to the Governor's Council on Disability	Jan. 15, 2010	Next Issue
10-09	Rescinds Executive Orders 95-10, 96-11, and 98-13 and terminates the Governor's Council on AIDS and transfers their duties to the Statewide HIV/STD Prevention Community Planning Group within the Department of Health and Senior Services	Jan. 15, 2010	Next Issue
10-08	Rescinds Executive Order 04-07 and terminates the Missouri Commission on Patient Safety	Jan. 15, 2010	Next Issue
10-07	Rescinds Executive Order 01-16 and terminates the Missouri Commission on Intergovernmental Cooperation	Jan. 15, 2010	Next Issue
10-06	Rescinds Executive Order 05-13 and terminates the Governor's Advisory Council on Plant Biotechnology and assigns its duties to the Missouri Technology Corporation	Jan. 15, 2010	Next Issue
10-05	Rescinds Executive Order 95-28 and terminates the Missouri Board of Geographic Names	Jan. 15, 2010	Next Issue
10-04	Rescinds Executive Order 03-10 and terminates the Missouri Energy Policy Council	Jan. 15, 2010	Next Issue
10-03	Rescinds Executive Order 03-01 and terminates the Missouri Lewis and Clark Bicentennial Commission	Jan. 15, 2010	Next Issue
10-02	Rescinds Executive Order 07-29 and terminates the Governor's Advisory Council on Aging and assigns its duties to the State Board of Senior Services	Jan. 15, 2010	Next Issue
10-01	Rescinds Executive Order 01-15 and terminates the Missouri Commission on Total Compensation	Jan. 15, 2010	Next Issue
	2009		
09-29	Outlines the suspension of federal commercial motor vehicle and driver laws during emergency declarations. Executive Orders 07-01 and 08-40 are superceded and replaced on February 1, 2010	December 31, 2009	This Issue
09-28	Establishes the post of Missouri Poet Laureate. Executive order 08-01 is superceded and replaced	December 24, 2009	This Issue
09-27	Creates the Missouri Office of Health Information Technology, referred to as MO-HITECH. Executive Order 06-03 is rescinded	November 4, 2009	34 MoReg 2587
09-26	Advises that state offices will be closed November 27, 2009	October 30, 2009	34 MoReg 2466
09-25	Creates the governor's faith-based and community service partnership for disaster recovery	September 21, 2009	34 MoReg 2361
09-24	Creates the prompt pay for a healthy Missouri project	September 11, 2009	34 MoReg 2313
09-23	Designates members of the governor's staff as having supervisory authority over departments, divisions, or agencies	September 1, 2009	34 MoReg 2139
09-22	Appoints the Home Building and Residential Energy Efficiency Advisory panel to issue recommendations on energy efficiency measures for the home building sector and consumers	August 20, 2009	34 MoReg 2137
09-21	Declares a state of emergency exists in the state of Missouri and directs that Missouri State Emergency Operations Plan remain activated	May 14, 2009	34 MoReg 1332
09-20	Gives the director of the Missouri Department of Natural Resources full discretionary authority to temporarily waive or suspend the operation of any statutory or administrative rule or regulation currently in place under his purview in order to best serve the interests of the public health and safety during the period of the emergency and the subsequent recovery period	May 12, 2009	34 MoReg 1331
09-19	Declares a state of emergency exists in the state of Missouri and directs that the Missouri State Emergency Operations Plan be activated	May 8, 2009	34 MoReg 1329

Executive Orders	Subject Matter	Filed Date	Publication
09-18	Orders that all state agencies whose building management falls under the direction of the Office of Administration shall institute policies that will result in reductions of energy consumption of two percent per year for each of the next ten years	April 23, 2009	34 MoReg 1273
09-17	Creates the Transform Missouri Project as well as the Taxpayer Accountability, Compliance, and Transparency Unit, and rescinds Executive Order 09-12	March 31, 2009	34 MoReg 828
09-16	Directs the Department of Corrections to lead a permanent, interagency steering team for the Missouri Reentry Process	March 26, 2009	34 MoReg 826
09-15	Expands the Missouri Automotive Jobs Task Force to consist of 18 members	March 24, 2009	34 MoReg 824
09-14	Designates members of the governor's staff as having supervisory authority over departments, divisions, or agencies	March 5, 2009	34 MoReg 761
09-13	Extends Executive Order 09-04 and Executive Order 09-07 through March 31, 2009	February 25, 2009	34 MoReg 657
09-12	Creates and establishes the Transform Missouri Initiative	February 20, 2009	34 MoReg 655
09-11	Orders the Department of Health and Senior Services and the Department of Social Services to transfer the Blindness Education, Screening and Treatment Program (BEST) to the Department of Social Services	February 4, 2009	34 MoReg 590
09-10	Orders the Department of Elementary and Secondary Education and the Department of Economic Development to transfer the Missouri Customized Training Program to the Department of Economic Development	February 4, 2009	34 MoReg 588
09-09	Transfers the various scholarship programs under the Departments of Agriculture, Elementary and Secondary Education, Higher Education, and Natural Resources to the Department of Higher Education	February 4, 2009	34 MoReg 585
09-08	Designates members of the governor's staff as having supervisory authority over departments, divisions, or agencies	February 2, 2009	34 MoReg 366
09-07	Gives the director of the Missouri Department of Natural Resources the authority to temporarily suspend regulations in the aftermath of severe weather that began on January 26	January 30, 2009	34 MoReg 364
09-06	Activates the state militia in response to the aftermath of severe storms that began on January 26	January 28, 2009	34 MoReg 362
09-05	Establishes a Complete Count Committee for the 2010 Census	January 27, 2009	34 MoReg 359
09-04	Declares a state of emergency and activates the Missouri State Emergency Operations Plan	January 26, 2009	34 MoReg 357
09-03	Directs the Missouri Department of Economic Development, working with the Missouri Development Finance Board, to create a pool of funds designated for low-interest and no-interest direct loans for small business	January 13, 2009	34 MoReg 281
09-02	Creates the Economic Stimulus Coordination Council	January 13, 2009	34 MoReg 279
09-01	Creates the Missouri Automotive Jobs Task Force	January 13, 2009	34 MoReg 277

The rule number and the MoReg publication date follow each entry to this index.

ACUPUNCTURIST ADVISORY COMMITTEE
fees; 20 CSR 2015-1.030; 5/15/09

ADMINISTRATION, OFFICE OF
appeals; 1 CSR 20-4.010; 1/15/10

AGRICULTURE
agricultural and small business development authority, Missouri
description of operation, definitions, fee structures, applicant requirements, and procedures for making and collecting loans and amending the rules for the single-purpose animal facilities loan guarantee program; 2 CSR 100-6.010; 12/1/09, 1/4/10
animal health
duties and facilities of the market/sale veterinarian; 2 CSR 30-6.020; 7/15/09, 12/15/09
health requirements governing the admission of livestock, poultry, and exotic animals entering Missouri; 2 CSR 30-2.010; 7/15/09, 12/15/09
movement of livestock, poultry, and exotic animals within Missouri; 2 CSR 30-2.020; 7/15/09, 12/15/09
requirements and responsibilities of market licensees; 2 CSR 30-6.015; 7/15/09, 12/15/09
milk board, state
animal health; 2 CSR 80-2.080; 9/1/09, 12/1/09
definitions; 2 CSR 80-2.010; 9/1/09, 12/1/09
enforcement; 2 CSR 80-2.151; 9/1/09, 12/1/09
examination of milk and milk products, the; 2 CSR 80-2.060; 9/1/09, 12/1/09
future dairy farms and milk plants; 2 CSR 80-2.121; 9/1/09, 12/1/09
inspection frequency and procedure; 2 CSR 80-2.050; 9/1/09, 12/1/09
labeling; 2 CSR 80-2.040; 9/1/09, 12/1/09
milk and milk products from points beyond the limits of routine inspection; 2 CSR 80-2.110; 9/1/09, 12/1/09
milk and milk products which may be sold; 2 CSR 80-2.091; 9/1/09, 12/1/09
penalty; 2 CSR 80-2.161; 9/1/09, 12/1/09
permits; 2 CSR 80-2.030; 9/1/09, 12/1/09
personnel health; 2 CSR 80-2.130; 9/1/09, 12/1/09
procedure when infection is suspected; 2 CSR 80-2.141; 9/1/09, 12/1/09
sale of adulterated, misbranded milk or milk products; 2 CSR 80-2.020; 9/1/09, 12/1/09
separability clause; 2 CSR 80-2.170; 9/1/09, 12/1/09
standards for milk and milk products; 2 CSR 80-2.070; 9/1/09, 12/1/09
transferring; delivery containers; cooling; 2 CSR 80-2.101; 9/1/09, 12/1/09

AIR QUALITY, AIR POLLUTION CONTROL
ambient air quality standards; 10 CSR 10-6.010; 11/2/09
clean air interstate rule annual NO_x trading program; 10 CSR 10-6.362; 8/3/09, 1/4/10
clean air interstate rule seasonal NO_x trading program; 10 CSR 10-6.364; 8/3/09, 1/4/10
clean air interstate rule SO_2 trading program; 10 CSR 10-6.366; 8/3/09, 1/4/10
control of NO_x emissions from large stationary internal combustion engines; 10 CSR 10-6.390; 10/1/09
controlling emissions during episodes of high air pollution; 10 CSR 10-6.130; 11/2/09
emission standards for hazardous air pollutants; 10 CSR 10-6.080; 11/2/09
maximum achievable control technology regulations; 10 CSR 10-6.075; 11/2/09
new source performance regulations; 10 CSR 10-6.070; 11/2/09
on-board diagnostics motor vehicle emissions inspection; 10 CSR 10-5.381; 11/3/08, 4/15/09
reference methods; 10 CSR 10-6.040; 11/2/09
start-up, shutdown and malfunctions conditions; 10 CSR 10-6.050; 12/15/09

ARCHITECTS, PROFESSIONAL ENGINEERS, PROFESSIONAL LAND SURVEYORS, AND LANDSCAPE ARCHITECTS
design of fire suppression systems; 20 CSR 2030-21.010; 9/1/09, 12/15/09
standard of care; 20 CSR 2030-2.040; 9/1/09, 12/15/09

BUSINESS AND COMMUNITY SERVICES, DIVISION OF
recovery zone bond allocation, waiver, and reallocation; 4 CSR 85-6.010; 11/2/09

CERTIFICATE OF NEED PROGRAM
application review schedul; 19 CSR 60-50; 2/1/10

CHIROPRACTIC EXAMINERS, STATE BOARD OF
application for certification of insurance consultant; 20 CSR 2070-4.020; 10/1/09, 1/15/10
biennial license renewal; 20 CSR 2070-2.080; 10/1/09, 1/15/10
chiropractic insurance consultant; 20 CSR 2070-4.010; 10/1/09, 1/15/10
fees; 20 CSR 2070-2.090; 10/1/09, 1/15/10
meridian therapy/acupressure/acupuncture; 20 CSR 2070-2.031; 10/1/09, 1/15/10
postgraduate education; 20 CSR 2070-2.081; 10/1/09, 1/15/10
renewal and postgraduate education; 20 CSR 2070-4.030; 10/1/09, 1/15/10

CLEAN WATER COMMISSION
effluent regulations; 10 CSR 20-7.015; 11/2/09
state revolving fund general assistance regulation; 10 CSR 20-4.040; 6/15/09, 7/1/09, 1/15/10
underground storage tanks
aboveground storage tanks—release response
applicability and definitions; 10 CSR 20-15.010; 5/1/09
release reporting and initial release response measures; 10 CSR 20-15.020; 5/1/09
site characterization and corrective action; 10 CSR 20-15.030; 5/1/09
administrative penalties
administrative penalty assessment; 10 CSR 20-13.080; 5/1/09, 1/4/10
financial responsibility
allowable mechanisms and combinations of mechanisms; 10 CSR 20-11.094; 5/1/09, 1/4/10
amount and scope of required financial responsibility; 10 CSR 20-11.093; 5/1/09, 1/4/10
applicability; 10 CSR 20-11.090; 5/1/09, 1/4/10
bankruptcy or other incapacity of owner or operator, or provider of financial assurance; 10 CSR 20-11.110; 5/1/09, 1/4/10
cancellation or nonrenewal by a provider of financial assurance; 10 CSR 20-11.105; 5/1/09, 1/4/10
compliance dates; 10 CSR 20-11.091; 5/1/09, 1/4/10
definitions of financial responsibility terms; 10 CSR 20-11.092; 5/1/09, 1/4/10

drawing on financial assurance mechanisms; 10 CSR 20-11.108; 5/1/09, 1/4/10
financial test of self-insurance; 10 CSR 20-11.095; 5/1/09, 1/4/10
guarantee; 10 CSR 20-11.096; 5/1/09, 1/4/10
insurance and risk retention group coverage; 10 CSR 20-11.097; 5/1/09, 1/4/10
letter of credit; 10 CSR 20-11.099; 5/1/09, 1/4/10
local government bond rating test; 10 CSR 20-11.112; 5/1/09, 1/4/10
local government financial test; 10 CSR 20-11.113; 5/1/09, 1/4/10
local government fund; 10 CSR 20-11.115; 5/1/09, 1/4/10
local government guarantee; 10 CSR 20-11.114; 5/1/09, 1/4/10
petroleum storage tank insurance fund; 10 CSR 20-11.101; 5/1/09, 1/4/10
record keeping; 10 CSR 20-11.107; 5/1/09, 1/4/10
release from the requirements; 10 CSR 20-11.109; 5/1/09, 1/4/10
replenishment of guarantees, letters of credit or surety bonds; 10 CSR 20-11.111; 5/1/09, 1/4/10
reporting by owner or operator; 10 CSR 20-11.106; 5/1/09, 1/4/10
standby trust fund; 10 CSR 20-11.103; 5/1/09, 1/4/10
substitution of financial assurance mechanisms by owner or operator; 20 CSR 11.104; 5/1/09, 1/4/10
surety bond; 10 CSR 20-11.098; 5/1/09, 1/4/10
trust fund; 10 CSR 20-11.102; 5/1/09, 1/4/10
technical regulations
assessing the property at closure or change in service; 10 CSR 20-10.072; 5/1/09, 1/4/10
applicability; 10 CSR 20-10.010; 5/1/09, 1/4/10
applicability to previously closed underground storage tank systems; 10 CSR 20-10.073; 5/1/09, 1/4/10
closure records; 10 CSR 20-10.074; 5/1/09, 1/4/10
compatibility; 10 CSR 20-10.032; 5/1/09, 1/4/10
corrective action plan; 10 CSR 20-10.066; 5/1/09, 1/4/10
definitions; 10 CSR 20-10.012; 5/1/09, 1/4/10
general requirements for release detection for all underground storage tank systems; 10 CSR 20-10.040; 5/1/09, 1/4/10
initial abatement measures, site check and comparison with default target levels; 10 CSR 20-10.062; 5/1/09, 1/4/10
initial release response; 10 CSR 20-10.061; 5/1/09, 1/4/10
initial site characterization; 10 CSR 20-10.063; 5/1/09, 1/4/10
interim prohibition for deferred underground storage tank systems; 10 CSR 20-10.011; 5/1/09, 1/4/10
investigation due to impacts on adjacent or nearby properties; 10 CSR 20-10.051; 5/1/09, 1/4/10
investigations for soil and groundwater cleanup; 10 CSR 20-10.65; 5/1/09, 1/4/10
light non-aqueous phase liquid (LNAPL) removal; 10 CSR 20-10.064; 5/1/09, 1/4/10
methods of release detection for piping; 10 CSR 20-10.044; 5/1/09, 1/4/10
methods of release detection for tanks; 10 CSR 20-10.043; 5/1/09, 1/4/10
notification requirements; 10 CSR 20-10.022; 5/1/09, 1/4/10
operation and maintenance of corrosion protection; 10 CSR 20-10.031; 5/1/09, 1/4/10
performance standards for new underground storage tank systems; 10 CSR 20-10.020; 5/1/09, 1/4/10
permanent closure and changes in service; 10 CSR 20-10.071; 5/1/09, 1/4/10
public participation and notice; 10 CSR 20-10.067; 5/1/09, 1/4/10
release detection record keeping; 10 CSR 20-10.045; 5/1/09, 1/4/10
release investigation and confirmation steps; 10 CSR 20-10.052; 5/1/09, 1/4/10
release reporting; 10 CSR 20-10.050; 5/1/09, 1/4/10
release response and corrective action; 10 CSR 20-10.060; 5/1/09, 1/4/10
repairs allowed; 10 CSR 20-10.033; 5/1/09, 1/4/10
reporting and cleanup of spills and overfills; 10 CSR 20-10.053; 5/1/09, 1/4/10
reporting and record keeping; 10 CSR 20-10.034; 5/1/09, 1/4/10
requirements for hazardous substance underground storage tank systems; 10 CSR 20-10.042; 5/1/09, 1/4/10
requirements for petroleum underground storage tank systems; 10 CSR 20-10.041; 5/1/09, 1/4/10
risk-based clean-up levels; 10 CSR 20-10.068; 5/1/09, 1/4/10
spill and overfill control; 10 CSR 20-10.030; 5/1/09, 1/4/10
temporary closure; 10 CSR 20-10.070; 5/1/09, 1/4/10
upgrading of existing underground storage tank systems; 10 CSR 20-10.021; 5/1/09, 1/4/10

CONSERVATION COMMISSION

commercial fishing: seasons, methods; 3 CSR 10-10.725; 11/2/09, 1/15/10
commercial musseling helper permit; 3 CSR 10-10.781; 11/2/09, 1/15/10
commercial musseling permit; 3 CSR 10-10.780; 11/2/09, 1/15/10
commercial musseling: seasons, methods; 3 CSR 10-10.782; 11/2/09, 1/15/10
decoys and blinds; 3 CSR 10-11.155; 11/2/09, 1/15/10
fishing, daily and possession limits
3 CSR 10-11.210; 11/2/09, 1/15/10
3 CSR 10-12.140; 11/2/09, 1/15/10
fishing, general provisions and seasons
3 CSR 10-11.200; 11/2/09, 1/15/10
3 CSR 10-12.130; 11/2/09, 1/15/10
fishing length limits
3 CSR 10-11.215; 11/2/09, 1/15/10
3 CSR 10-12.145; 11/2/09, 1/15/10
fishing methods
3 CSR 10-6.410; 11/2/09, 1/15/10
3 CSR 10-12.135; 11/2/09, 1/15/10
fishing, methods and hours; 3 CSR 10-11.205; 11/2/09, 1/15/10
furbearers: trapping seasons; 3 CSR 10-8.515; 11/2/09, 1/15/10
general prohibition; applications; 3 CSR 10-9.110; 11/2/09, 1/15/10
hunting and trapping; 3 CSR 10-12.125; 11/2/09, 1/15/10
hunting, general provisions and seasons; 3 CSR 10-11.180; 11/2/09, 1/15/10
licensed trout fishing area permit: privileges, requirements; 3 CSR 10-9.645; 11/2/09, 1/15/10
migratory bird hunting permit; 3 CSR 10-5.435; 9/15/09, 12/15/09
mussel dealer's permit; 3 CSR 10-10.783; 11/2/09, 1/15/10
mussel dealers: reports, requirements; 3 CSR 10-10.784; 11/2/09, 1/15/10
other fish; 3 CSR 10-6.550; 11/2/09, 1/15/10
privileges of class I and class II wildlife breeders; 3 CSR 10-9.353; 11/2/09, 1/15/10
reciprocal privileges: commercial fishing; commercial waters; 3 CSR 10-10.726; 11/2/09, 1/15/10
record keeping and reporting required: commercial fishermen; 3 CSR 10-10.727; 11/2/09, 1/15/10
reports required: commercial musselers; 3 CSR 10-10.787; 11/2/09, 1/15/10

taxidermy; tanning: permit, privileges, requirements; 3 CSR 10-10.767; 11/2/09, 1/15/10
transportation; 3 CSR 10-4.135; 11/2/09, 1/15/10
turkeys: seasons, methods, limits; 3 CSR 10-7.455; 2/1/10
use of boats and motors; 3 CSR 10-12.110; 11/2/09, 1/15/10
vehicles, bicycles, equestrian use; 3 CSR 10-11.130; 11/2/09, 1/15/10
wildlife collector's permit; 3 CSR 10-9.425; 11/2/09, 1/15/10
youth firearms antlerless deer hunting permit; 3 CSR 10-5.422; 11/2/09, 1/15/10

COSMETOLOGY AND BARBER EXAMINERS, BOARD OF
apprentice supervisors; 20 CSR 2085-9.020; 9/1/09, 12/15/09
esthetic schools; 20 CSR 2085-12.080; 9/1/09, 12/15/09
fees; 20 CSR 2085-3.010; 7/15/09, 9/1/09, 12/15/09
manicuring schools; 20 CSR 2085-12.070; 9/1/09, 12/15/09
specific requirements for cosmetology schools; 20 CSR 2085-12.040; 9/1/09, 12/15/09

CREDIT UNION COMMISSION
definition—low-income or underserved community; 20 CSR 1105-3.012; 11/16/09
definitions—immediate family and household; 20 CSR 1105-3.010; 11/16/09

ELEMENTARY AND SECONDARY EDUCATION, DEPARTMENT OF
administration of high school equivalence program; 5 CSR 60-100.020; 1/4/10, 2/1/10
general provisions governing programs authorized under the early childhood development act; 5 CSR 50-270.010; 2/1/10
Missouri school improvement program–fifth cycle; 5 CSR 50-345.105; 10/1/09
waiver of regulations–fifth cycle; 5 CSR 50-345.205; 10/1/09

EMBALMERS AND FUNERAL DIRECTORS, STATE BOARD OF
change in seller affiliation; 20 CSR 2120-3.310; 1/15/10
contact information; 20 CSR 2120-3.115; 1/15/10
corporate ownership of a license; 20 CSR 2120-3.125; 11/2/09
definitions; 20 CSR 2120-1.040; 9/1/09, 12/15/09
display of license; 20 CSR 2120-3.120; 1/15/10
embalmer's registration and apprenticeship; 20 CSR 2120-2.010; 9/1/09
fees; 20 CSR 2120-2.100; 11/2/09
filing of annual reports; 20 CSR 2120-3.150; 11/2/09
final disposition as defined in chapter 193; 20 CSR 2120-2.130; 1/15/10
financial welfare cause for injection; 20 CSR 2120-2.140; 1/15/10
funeral directing; 20 CSR 2120-2.060; 9/1/09, 12/15/09
funeral director agent restrictions; 20 CSR 2120-3.305; 1/15/10
independent financial advisor is agent of trustee; 20 CSR 2120-3.525; 1/15/10
licensure by reciprocity; 20 CSR 2120-2.040; 9/1/09, 12/15/09
notice of intent to apply; 20 CSR 2120-3.100; 10/1/09, 11/16/09
payment not determining factor of practice of funeral directing; 20 CSR 2120-2.150; 1/15/10
preneed agents—Missouri law exam; 20 CSR 2120-3.405; 11/2/09, 11/16/09
preneed agents—requirements of agent's seller; 20 CSR 2120-3.400; 1/15/10
preneed agents's seller must be licensed; 20 CSR 2120-3.410; 1/15/10
provider includes funeral establishment; 20 CSR 2120-3.300; 1/15/10
seller obligations; 20 CSR 2120-3.200; 1/15/10
single premium annuity contracts; 20 CSR 2120-3.515; 1/15/10
types of financing; other financing still preneed; 20 CSR 2120-3.505; 1/15/10

EXECUTIVE ORDERS
creates the Missouri office of health information technology, referred to as MO-HITECH. Executive Order 06-03 is rescinded; 09-27; 12/15/09
establishes the post of Missouri Poet Laureate. Executive Order 08-01 is superceded and replaced; 09-28; 2/1/10
outlines the suspension of federal commercial motor vehicle and driver laws during emergency declarations. Executive Orders 07-01 and 08-40 are superceded and replaced on February 1, 2010; 09-29; 2/1/10

FERTILIZER LAW
guaranteed analysis when tonnage inspection fee is based on product constituent; 6 CSR 250-11.042; 12/15/09
inspection fee on manipulated animal or vegetable manure fertilizers; 6 CSR 250-11.041; 12/15/09, 2/1/10

FUEL STANDARD, MISSOURI RENEWABLE
organization, definitions; 2 CSR 110-3.010; 2/1/08
quality standards; 2 CSR 90-30.040; 2/15/08

GAMING COMMISSION, MISSOURI
chip specifications; 11 CSR 45-5.100; 8/3/09, 12/15/09
junket, junket enterprises, junket representatives
agreements, schedules, and reports; 11 CSR 45-4.540; 9/1/09
definitions; 11 CSR 45-4.500; 9/1/09
licensing requirements; 11 CSR 45-4.510; 9/1/09
patron selection; 11 CSR 45-4.520; 9/1/09
policies and prohibited activities; 11 CSR 45-4.530; 9/1/09
license renewal; 11 CSR 45-4.190; 9/1/09
licenses, restrictions on licenses, licensing authority of the executive director and other definitions; 11 CSR 45-4.020; 9/1/09
prohibition and reporting of certain transactions; 11 CSR 45-10.040; 1/15/10
supplier's license; 11 CSR 45-4.200; 9/1/09
taxation regulations
admission fee; 11 CSR 45-11.050; 1/15/10
deposit account—taxes and fees;11 CSR 45-11.020; 1/15/10
failure to file return or pay tax or fee; 11 CSR 45-11.130; 1/15/10
payment—gaming tax; 11 CSR 45-11.030; 1/15/10
return and payment—admission fee; 11 CSR 45-11.070; 1/15/10

GEOLOGIST REGISTRATION, MISSOURI BOARD OF
licensure requirements; 20 CSR 2145-2.040; 10/1/09, 1/15/10
post-baccalaureate experience in geology; 20 CSR 2145-2.030; 10/1/09, 1/15/10

HAZARDOUS WASTE MANAGEMENT COMMISSION
electronics scrap management; 10 CSR 25-19.010; 8/3/09

HEALING ARTS, STATE BOARD OF
acceptable continuing education
physical therapists and physical therapist assistants; 20 CSR 2150-3.203; 10/1/09, 1/15/10
speech-language pathologists and audiologists; 20 CSR 2150-4.053; 10/1/09, 1/15/10
administration of vaccines per protocol; 20 CSR 2150-5.025; 12/1/09
licensing of international medical graduates–reciprocity; 20 CSR 2150-2.100; 10/1/09, 1/15/10
limited license; 20 CSR 2150-2.155; 10/1/09, 1/15/10
nonpharmacy dispensing; 20 CSR 2150-5.020; 9/15/09, 12/15/09
request for waiver; 20 CSR 2150-7.136; 10/1/09
temporary licenses—physical therapists; 20 CSR 2150-3.050; 5/1/09, 10/1/09

HEALTH AND SENIOR SERVICES, DEPARTMENT OF
community and public health
minimum construction standards for on-site sewage disposal

systems; 19 CSR 20-3.060; 8/15/08
fees charged by Department of Health for inspection of existing on-site sewage disposal system required by a lending institution; 19 CSR 20-3.070; 12/1/08, 4/1/09
regulation and licensure
administrative penalties; 19 CSR 30-70.650; 8/17/09, 1/15/10
application and licensure requirements for the initial licensure and relicensure of emergency medical technician-basic, emergency medical technician-intermediate, and emergency medical technician-paramedics; 19 CSR 30-40.342; 2/17/09, 10/1/09

HIGHWAYS AND TRANSPORTATION COMMISSION
breath alcohol ignition interlock device certification and operational David's law signing
administration; 7 CSR 10-27.040; 10/15/09
definitions; 7 CSR 10-27.010; 10/15/09
eligibility requirements; 7 CSR 10-27.020; 10/15/09
sign design and installation; 7 CSR 10-27.030; 10/15/09
procurement of supplies
bidder registration, official mailing lists, suspension from list; 7 CSR 10-11.030; 7/15/09, 12/15/09
definition of terms; 7 CSR 10-11.010; 7/15/09, 12/15/09
procedures for solicitation, receipt of bids, and awards of contract; 7 CSR 10-11.020; 7/15/09, 12/15/09
procedures for solicitation, receipt of bids, and award and administration of contracts; 7 CSR 10-11.020; 7/15/09, 12/15/09
vendor registration, notification of competitive bidding opportunities, suspension, and debarment; 7 CSR 10-11.030; 7/15/09, 12/15/09
skill performance evaluation certificates for commercial drivers; 7 CSR 10-25.010; 12/15/09, 2/1/10

INSURANCE
insurance solvency and company regulation
financial statement and electronic filing; 20 CSR 200-1.030; 8/17/09, 1/4/10
materials incorporated by reference; 20 CSR 200-1.005; 8/17/09, 1/4/10
property and casualty actuarial opinions; 20 CSR 200-1.105; 10/1/09, 2/1/10
life, annuities, and health
dependent coverage; 20 CSR 400-2.200; 3/2/09
medicare supplement insurance minimum standards act; 20 CSR 400-3.650; 8/3/09, 9/1/09, 2/1/10
medical malpractice
statistical data reporting; 20 CSR 600-1.030; 7/2/07
sovereign immunity limits; 20 CSR; 2/1/10
statistical reporting
medical malpractice statistical data reporting; 20 CSR 600-1.030; 10/15/08

INTERPRETERS, MISSOURI STATE COMMITTEE OF
certifications recognized by the board; 20 CSR 2232-2.040; 10/1/09, 1/15/10

LABOR AND INDUSTRIAL RELATIONS
employment security, division of
maintenance and disposal of records; 8 CSR 10-2.010; 9/15/09, 1/4/10
reemployment trade adjustment assistance program; 8 CSR 10-3.140; 10/1/09, 1/15/10
workers' compensation, division of
organization of division of workers' compensation; 8 CSR 50-1.010; 11/16/09

MASSAGE, BOARD OF THERAPEUTIC
apprenticeship training documentation; 20 CSR 2197-4.040; 10/1/09, 1/15/10
apprenticeship training program; 20 CSR 2197-4.030; 10/1/09, 1/15/10
certified mentor; 20 CSR 2197-4.010; 10/1/09, 1/15/10
provisional license; 20 CSR 2197-2.030; 10/1/09, 1/15/10

MEDICAL SERVICES, DIVISION OF
grant to trauma hospital; 13 CSR 70-15.180; 7/16/07
reimbursement
HIV services; 13 CSR 70-10.080; 10/15/07
nursing services; 13 CSR 70-10.015; 10/15/07
Title XIX
claims, false or fraudulent; 13 CSR 70-3.030; 5/1/07

MENTAL HEALTH, DEPARTMENT OF
assertive community treatment programs; 9 CSR 30-4.0432; 9/15/09, 2/1/10
standard means test; 9 CSR 10-31.011; 1/4/10

MO HEALTHNET
dental benefits and limitations, MO HealthNet program; 13 CSR 70-35.010; 9/15/09, 1/4/10
federal reimbursement allowance (FRA); 13 CSR 70-15.110; 7/15/09, 8/3/09, 12/15/09, 1/4/10
filing of claims, MO HealthNet program; 13 CSR 70-3.100; 9/15/09, 1/4/10
global per diem adjustments to nursing facility and HIV nursing facility reimbursement rates; 13 CSR 70-10.016; 11/17/08, 8/3/09, 12/15/09
home health-care services; 13 CSR 70-90.010; 9/15/09, 1/4/10
home health-care services reimbursement; 13 CSR 70-90.020; 9/15/09, 1/4/10
inpatient hospital services reimbursement plan; outpatient hospital services reimbursement methodology; 13 CSR 70-15.010; 9/1/09, 2/1/10
insure Missouri; 13 CSR 70-4.120; 2/15/08
list of non-excludable drugs for which prior authorization is required; 13 CSR 70-20.034; 9/15/09, 1/4/10
medicaid managed care organization reimbursement allowance; 13 CSR 70-3.170; 8/3/09, 12/1/09
nursing facility reimbursement allowance; 13 CSR 70-10.110; 8/3/09, 12/15/09, 1/4/10
optical benefits and limitations–MO HealthNet program; 13 CSR 70-40.010; 9/15/09, 1/4/10
pharmacy reimbursement allowance; 13 CSR 70-20.320; 8/3/09, 12/15/09, 1/4/10
private duty nursing; 13 CSR 70-95.010; 9/15/09, 1/4/10
sanctions for false or fraudulent claims for MO HealthNet services; 13 CSR 70-3.030; 9/15/09, 1/4/10

MISSOURI CONSOLIDATED HEALTH CARE PLAN
public entity membership
copay plan benefit provisions and covered charges; 22 CSR 10-3.050; 2/1/10
definitions; 22 CSR 10-3.010; 2/1/10
high deductible health plan benefit provisions and covered charges; 22 CSR 10-3.055; 2/1/10
pharmacy benefit summary; 22 CSR 10-3.090; 2/1/10
plan utilization review policy; 22 CSR 10-3.045; 2/1/10
PPO 300 plan benefit provisions and covered charges; 22 CSR 10-3.051; 2/1/10
PPO 300 plan, PPO 500 plan, PPO 1000 plan, PPO 2000 plan, HDHP, and copay plan limitations; 22 CSR 10-3.060; 2/1/10
PPO 500 plan benefit provisions and covered charges; 22 CSR 10-3.052; 2/1/10
PPO 1000 plan benefit provisions and covered charges; 22 CSR 10-3.053; 2/1/10
PPO 2000 plan benefit provisions and covered charges; 22 CSR 10-3.054; 2/1/10
public entity membership agreement and participation period; 22 CSR 10-3.030; 2/1/10
subscriber agreement and general membership provisions; 22 CSR 10-3.020; 2/1/10
state membership
copay plan benefit provisions and covered charges; 22 CSR 10-2.050; 2/1/10
definitions; 22 CSR 10-2.010; 2/1/10

high deductible health plan benefit provisions and covered charges; 22 CSR 10-2.053; 2/1/10
HMO and POS limitations; 22 CSR 10-2.067; 2/1/10
HMO summary of medical benefits; 22 CSR 10-2.064; 2/1/10
medical plan benefit provisions and covered charges; 22 CSR 10-2.055; 2/1/10
medicare supplement plan benefit provisions and covered charges; 22 CSR 10-2.054; 2/1/10
pharmacy benefit summary; 22 CSR 10-2.090; 2/1/10
plan utilization review policy; 22 CSR 10-2.045; 2/1/10
PPO 300 plan benefit provisions and covered charges; 22 CSR 10-2.051; 2/1/10
PPO 300 plan, HDHP, copay and HMO plan limitations; 22 CSR 10-2.060; 2/1/10
subscriber agreement and general membership provisions; 22 CSR 10-2.020; 2/1/10

NATURAL RESOURCES, DEPARTMENT OF
consolidation of permit processing; 10 CSR 1-3.010; 11/2/09

NURSING, STATE BOARD OF
graduate temporary permit; 20 CSR 2200-4.021; 11/16/09
nurse licensure compact; 20 CSR 2200-4.022; 11/16/09
requirements for licensure; 20 CSR 2200-4.020; 10/1/09, 1/15/10

OCCUPATIONAL THERAPY, MISSOURI BOARD OF
fees; 20 CSR 2205-1.050; 5/15/09

PETROLEUM AND HAZARDOUS SUBSTANCE STORAGE TANKS
underground storage tanks
aboveground storage tanks—release response
applicability and definitions; 10 CSR 20-15.010; 5/1/09
release reporting and initial release response measures; 10 CSR 20-15.020; 5/1/09
site characterization and corrective action; 10 CSR 20-15.030; 5/1/09
administrative penalties
administrative penalty assessment; 10 CSR 26-4.080; 5/1/09, 1/4/10
financial responsibility
allowable mechanisms and combinations of mechanisms; 10 CSR 26-3.094; 5/1/09, 1/4/10
amount and scope of required financial responsibility; 10 CSR 26-3.093; 5/1/09, 1/4/10
applicability; 10 CSR 26-3.090; 5/1/09, 1/4/10
bankruptcy or other incapacity of owner or operator, or provider of financial assurance; 10 CSR 26-3.110; 5/1/09, 1/4/10
cancellation or nonrenewal by a provider of financial assurance; 10 CSR 26-3.105; 5/1/09, 1/4/10
compliance dates; 10 CSR 26-3.091; 5/1/09, 1/4/10
definitions of financial responsibility terms; 10 CSR 26-3.092; 5/1/09, 1/4/10
drawing on financial assurance mechanisms; 10 CSR 26-3.108; 5/1/09, 1/4/10
financial test of self-insurance; 10 CSR 26-3.095; 5/1/09, 1/4/10
guarantee; 10 CSR 26-3.096; 5/1/09, 1/4/10
insurance and risk retention group coverage; 10 CSR 26-3.097; 5/1/09, 1/4/10
letter of credit; 10 CSR 26-3.099; 5/1/09, 1/4/10
local government bond rating test; 10 CSR 26-3.112; 5/1/09, 1/4/10
local government financial test; 10 CSR 26-3.113; 5/1/09, 1/4/10
local government fund; 10 CSR 26-3.115; 5/1/09, 1/4/10
local government guarantee; 10 CSR 26-3.114; 5/1/09, 1/4/10
petroleum storage tank insurance fund; 10 CSR 26-3.101; 5/1/09, 1/4/10
record keeping; 10 CSR 26-3.107; 5/1/09, 1/4/10
release from the requirements; 10 CSR 26-3.109; 5/1/09, 1/4/10
replenishment of guarantees, letters of credit or surety bonds; 10 CSR 26-3.111; 5/1/09, 1/4/10
reporting by owner or operator; 10 CSR 26-3.106; 5/1/09, 1/4/10
standby trust fund; 10 CSR 26-3.103; 5/1/09, 1/4/10
substitution of financial assurance mechanisms by owner or operator; 26 CSR 3.104; 5/1/09, 1/4/10
surety bond; 10 CSR 26-3.098; 5/1/09, 1/4/10
trust fund; 10 CSR 26-3.102; 5/1/09, 1/4/10
organization; 10 CSR 26-1.010; 5/1/09, 1/4/10
technical regulations
assessing the property at closure or change in service; 10 CSR 26-2.062; 5/1/09, 1/4/10
applicability; 10 CSR 26-2.010; 5/1/09, 1/4/10
applicability to previously closed underground storage tank systems; 10 CSR 26-2.063; 5/1/09, 1/4/10
closure records; 10 CSR 26-2.064; 5/1/09, 1/4/10
compatibility; 10 CSR 26-2.032; 5/1/09, 1/4/10
corrective action plan; 10 CSR 26-2.079; 5/1/09, 1/4/10
definitions; 10 CSR 26-2.012; 5/1/09, 1/4/10
general requirements for release detection for all underground storage tank systems; 10 CSR 26-2.040; 5/1/09, 1/4/10
initial abatement measures, site check and comparison with default target levels; 20 CSR 26-2.072; 5/1/09, 1/4/10
initial release response; 10 CSR 26-2.071; 5/1/09, 1/4/10
initial site characterization; 10 CSR 26-2.073; 5/1/09, 1/4/10
interim prohibition for deferred underground storage tank systems; 10 CSR 26-2.011; 5/1/09, 1/4/10
investigation due to impacts on adjacent or nearby properties; 10 CSR 26-2.051; 5/1/09, 1/4/10
light non-aqueous phase liquid (LNAPL) removal; 10 CSR 26-2.074; 5/1/09, 1/4/10
long-term stewardship; 10 CSR 26-2.081; 5/1/09, 1/4/10
methods of release detection for piping; 10 CSR 26-2.044; 5/1/09, 1/4/10
methods of release detection for tanks; 10 CSR 26-2.043; 5/1/09, 1/4/10
no further remedial action determinations; 10 CSR 26-2.082; 5/1/09, 1/4/10
notification requirements; 10 CSR 26-2.022; 5/1/09, 1/4/10
operation and maintenance of corrosion protection; 10 CSR 26-2.031; 5/1/09, 1/4/10
performance standards for new underground storage tank systems; 10 CSR 26-2.020; 5/1/09, 1/4/10
permanent closure and changes in service; 10 CSR 26-2.061; 5/1/09, 1/4/10
public participation and notice; 10 CSR 26-2.080; 5/1/09, 1/4/10
release detection record keeping; 10 CSR 26-2.045; 5/1/09, 1/4/10
release investigation and confirmation steps; 10 CSR 26-2.052; 5/1/09, 1/4/10
release reporting; 10 CSR 26-2.050; 5/1/09, 1/4/10
release response and corrective action; 10 CSR 26-2.070; 5/1/09, 1/4/10
repairs allowed; 10 CSR 26-2.033; 5/1/09, 1/4/10
reporting and cleanup of spills and overfills; 10 CSR 26-2.053; 5/1/09, 1/4/10

reporting and record keeping; 10 CSR 26-2.034; 5/1/09, 1/4/10
requirements for hazardous substance underground storage tank systems; 10 CSR 26-2.042; 5/1/09, 1/4/10
requirements for petroleum underground storage tank systems; 10 CSR 26-2.041; 5/1/09, 1/4/10
risk-based corrective action process; 10 CSR 26-2.075; 5/1/09, 1/4/10
risk-based target levels; 10 CSR 26-2.077; 5/1/09, 1/4/10
site characterization and data requirements; 10 CSR 26-2.076; 5/1/09, 1/4/10
spill and overfill control; 10 CSR 26-2.030; 5/1/09, 1/4/10
tiered risk assessment process; 10 CSR 26-2.078; 5/1/09, 1/4/10
temporary closure; 10 CSR 26-2.070; 5/1/09, 1/4/10
upgrading of existing underground storage tank systems; 10 CSR 26-2.021; 5/1/09, 1/4/10

PHARMACY, STATE BOARD OF
administration of vaccines per protocol; 20 CSR 2220-6.050; 12/1/09
non-dispensing activities; 20 CSR 2220-6.055; 12/1/09
pharmacy technician registration; 20 CSR 2220-2.700; 10/1/09, 2/1/10
well-being program; 20 CSR 2220-2.175; 10/1/09, 2/1/10

PRIVATE INVESTIGATOR EXAMINERS, BOARD OF
application for licensure
licensed agency investigator employee; 20 CSR 2234-3.040; 8/3/09, 12/15/09
private investigator; 20 CSR 2234-2.010; 8/3/09, 12/15/09
private investigator agency; 20 CSR 2234-3.010; 8/3/09, 12/15/09
private investigator trainer; 20 CSR 2234-4.010; 8/3/09, 12/15/09
change of name, ownership, location, or private investigator-in-charge–private investigator agency; 20 CSR 2234-3.020; 8/3/09, 12/15/09
code of conduct; 20 CSR 2234-7.010; 8/3/09, 12/15/09
complaint handling and disposition; 20 CSR 2234-1.040; 8/3/09, 12/15/09
continuing education; 20 CSR 2234-6.010; 8/3/09, 12/15/09
definitions; 20 CSR 2234-1.010; 8/3/09, 12/15/09
examination; 20 CSR 2234-5.010; 8/3/09, 12/15/09
fees; 20 CSR 2234-1.050; 8/3/09, 12/15/09
general organization; 20 CSR 2234-1.020; 8/3/09, 12/15/09
licensure renewal
licensed agency investigator employee; 20 CSR 2234-3.070; 8/3/09, 12/15/09
private investigator; 20 CSR 2234-2.040; 8/3/09, 12/15/09
private investigator agency; 20 CSR 2234-3.030; 8/3/09, 12/15/09
private investigator trainer; 20 CSR 2234-4.050; 8/3/09, 12/15/09
name and address changes
licensed agency investigator employee; 20 CSR 2234-3.050; 8/3/09, 12/15/09
private investigator; 20 CSR 2234-2.020; 8/3/09, 12/15/09
private investigator trainer; 20 CSR 2234-4.030; 8/3/09, 12/15/09
policy for release of public records; 20 CSR 2234-1.030; 8/3/09, 12/15/09
replacement of renewal license
licensed agency investigator employee; 20 CSR 2234-3.060; 8/3/09, 12/15/09
private investigator; 20 CSR 2234-2.030; 8/3/09, 12/15/09
private investigator trainer; 20 CSR 2234-4.040; 8/3/09, 12/15/09
trainer responsibilities–private investigator trainer; 20 CSR 2234-4.020; 8/3/09, 12/15/09

PUBLIC DRINKING WATER PROGRAM
drinking water revolving fund loan program; 10 CSR 60-13.020; 7/1/09, 8/3/09, 12/15/09

PUBLIC SAFETY, DEPARTMENT OF
Fire Safety, Division of
certificates, inspections, and fees; 11 CSR 40-2.022; 8/3/09, 1/4/10
code/standards adopted by board; 11 CSR 40-2.015; 8/3/09, 1/4/10
definitions; 11 CSR 40-2.010; 8/3/09, 1/4/10
heating boilers; 11 CSR 40-2.040; 8/3/09, 1/4/10
new installations; 11 CSR 40-2.061; 8/3/09, 1/4/10
power boilers; 11 CSR 40-2.030; 8/3/09, 1/4/10
Missouri State Highway Patrol
school bus inspection; 11 CSR 50-2.320; 9/15/09, 1/4/10
Missouri State Water Patrol
filing requirements; 11 CSR 80-5.010; 2/17/09

PUBLIC SERVICE COMMISSION
conduct during proceedings; 4 CSR 240-4.020; 12/15/09
customer proprietary network information; 4 CSR 240-33.160; 2/1/10
ex parte and extra-record communications; 4 CSR 240-4.020; 12/15/09
filing requirements for telecommunications company tariffs; 4 CSR 240-3.545; 2/1/10
reporting requirements for electric utilities and rural electric cooperatives; 4 CSR 240-3.190; 2/1/10

REAL ESTATE APPRAISERS
application, certificate, and license fees; 20 CSR 2245-5.020; 5/1/09, 10/1/09, 1/15/10
applications for certification and licensure; 20 CSR 2245-3.010; 10/1/09, 2/1/10
case study courses; 20 CSR 2245-6.040; 10/1/09, 1/15/10
examination and education requirements; 20 CSR 2245-6.015; 10/1/09, 2/1/10
general organization; 20 CSR 2245-1.010; 10/1/09, 1/15/10
instructor approval; 20 CSR 2245-8.030; 10/1/09, 1/15/10
nonresident certification or licensure; reciprocity; 20 CSR 2245-4.050; 10/1/09, 2/1/10
requirements; 20 CSR 2245-8.010; 10/1/09, 1/15/10
temporary nonresident certificate or license; 20 CSR 2245-4.060; 10/1/09, 2/1/10
trainee real estate appraiser registration; 20 CSR 2245-3.005; 6/1/09, 9/15/09, 10/1/09, 1/15/10

REAL ESTATE COMMISSION, MISSOURI
applications for license; 20 CSR 2250-3.010; 10/1/09, 1/15/10
expiration and renewal; name and address changes; 20 CSR 2250-4.020; 10/1/09, 1/15/10
investigation; 20 CSR 2250-9.020; 10/1/09, 1/15/10

RECORDS MANAGEMENT
Missouri historical records advisory board (MHRAB) regrant program administration; 15 CSR 30-45.040; 7/15/09

RETIREMENT SYSTEMS
county employees' retirement fund, the
payment of benefits; 16 CSR 50-2.035; 10/1/09, 2/1/10
determination of amount otherwise payable during deflation; 16 CSR 20-2.105; 12/15/09

determination of credited service for periods of absence; 16 CSR 20-2.080; 1/15/10
disability retirement
16 CSR 10-5.020; 2/1/10
16 CSR 10-6.070; 2/1/10
service retirement
16 CSR 10-5.010; 2/1/10
16 CSR 10-6.060; 2/1/10
workers' compensation service credit; 16 CSR 20-2.080; 1/15/10

SOCIAL WORKERS, STATE COMMITTEE FOR
acceptable supervisors and supervisor responsibilities; 20 CSR 2263-2.031; 10/1/09
application for licensure as a licensed baccalaureate social worker; 20 CSR 2263-2.052; 10/1/09
application for licensure as a social worker; 20 CSR 2263-2.050; 10/1/09
client relationships; 20 CSR 2263-3.040; 10/1/09
competence; 20 CSR 2263-3.140; 10/1/09
confidentiality; 20 CSR 2263-3.100; 10/1/09
continuing education; 20 CSR 2263-2.082; 10/1/09
definitions; 20 CSR 2263-1.010; 10/1/09
educational requirements for licensed baccalaureate social workers; 20 CSR 2263-2.022; 10/1/09
educational requirements for licensed social workers; 20 CSR 2263-2.020; 10/1/09
fees; 20 CSR 2263-1.035; 10/1/09
inactive status; 20 CSR 2263-2.090; 10/1/09
licensure by reciprocity; 20 CSR 2263-2.060; 10/1/09
licensure by reciprocity as a licensed baccalaureate social worker; 20 CSR 2263-2.062; 10/1/09
moral standards; 20 CSR 2263-3.020; 10/1/09
provisional licensed baccalaureate social worker; 20 CSR 2263-2.047; 10/1/09
provisional licenses; 20 CSR 2263-2.045; 10/1/09
public statements/fees; 20 CSR 2263-3.080; 10/1/09
registration of supervised social work experience; 20 CSR 2263-2.032; 10/1/09
relationships with colleagues; 20 CSR 2263-3.060; 10/1/09
renewal of license; 20 CSR 2263-2.075; 10/1/09
research on human subjects; 20 CSR 2263-3.120; 10/1/09
restoration of license; 20 CSR 2263-2.085; 10/1/09
scope of coverage and organization; 20 CSR 2263-3.010; 10/1/09
supervised licensed social work experience; 20 CSR 2263-2.030; 10/1/09
temporary permits for licensed baccalaureate social workers; 20 CSR 2263-2.072; 10/1/09
temporary permits for licensed social workers; 20 CSR 2263-2.070; 10/1/09

SOIL AND WATER DISTRICTS COMMISSION
allocation of funds; 10 CSR 70-5.010; 2/1/10
application and eligibility for funds; 10 CSR 70-5.020; 9/1/09
apportionment of funds; 10 CSR 70-5.010; 9/1/09
commission administration of the cost-share program; 10 CSR 70-5.060; 9/1/09, 2/1/10
conservation equipment incentive program; 10 CSR 70-9.010; 9/15/08
cost-share rates and reimbursement procedures; 10 CSR 70-5.040; 9/1/09, 2/1/10
definitions; 10 CSR 70-4.010; 2/1/10
design, layout and construction of proposed practices; operation and maintenance; 10 CSR 70-5.030; 9/1/09
district administration of the cost-share program; 10 CSR 70-5.050; 9/1/09, 2/1/10

STATE AUDITOR
contents of audit reports; 15 CSR 40-4.030; 2/1/10
requirements for districts; 15 CSR 40-4.010; 2/1/10
scope of audit; 15 CSR 40-4.040; 2/1/10
standards for auditing and financial reporting; 15 CSR 40-4.020; 2/1/10

STATE TAX COMMISSION
agricultural land productive values; 12 CSR 30-4.010; 2/1/10
appeals from the local board of equalization; 12 CSR 30-3.010; 2/1/10
collateral estoppel; 12 CSR 30-3.025; 2/1/10

TATTOOING, BODY PIERCING, AND BRANDING, OFFICE OF
fees; 20 CSR 2267-2.020; 5/15/09
initiation of disciplinary proceedings; 20 CSR 2267-6.030; 9/1/09, 12/15/09
licenses; 20 CSR 2267-2.010; 9/1/09, 12/15/09

TAX
annual adjusted rate of interest; 12 CSR 10-41.010; 12/1/09
income tax
Missouri consolidated income tax returns; 12 CSR 10-2.045; 1/4/10
sales or use
farm machinery and equipment related exemptions; 12 CSR 10-110.900; 11/16/09
no waiver of tax; 12 CSR 10-3.562; 8/17/09, 12/1/09

TREASURER
interest rate on linked deposit loans; 15 CSR 50-2.050; 12/1/09

VETERINARY MEDICAL BOARD, MISSOURI
minimum standards for continuing education for veterinarians; 20 CSR 2270-4.042; 9/1/09, 12/15/09
reexamination; 20 CSR 2095-2.041; 1/2/09, 4/15/09

To Subscribe to the *Missouri Register*

SALUS POPULI SUPREMA LEX ESTO
"The welfare of the people shall be the supreme law."

ROBIN CARNAHAN
SECRETARY OF STATE

MISSOURI
REGISTER

Contact us at: phone: (573) 751-4015 or email: rules@sos.mo.gov

ORDER FORM

☐ Enclosed is my check for $56 as payment in advance for one year of the *Missouri Register*
Please start my subscription with the _____issue.

Please make checks payable to: **Secretary of State** or alternatively call us to charge your credit card.

Mail to: ROBIN CARNAHAN
SECRETARY OF STATE
ADMINISTRATIVE RULES DIVISION
PO BOX 1767
JEFFERSON CITY, MO 65102

_____
Name or Firm (Please Type or Print) Attn:

_____
Address

_____
City State Zip Code

ROBIN CARNAHAN
SECRETARY OF STATE
PO BOX 1767
JEFFERSON CITY, MO 65102

Periodical
Postage Paid at
Jefferson City,
MO

HB 191, effective August 28, 2009, has resulted in changes to the information required in the certification letter that accompanies proposed rulemakings. A new certification letter containing the required information is available for use on the Office of the Secretary of State's website at http://www.sos.mo.gov/adrules/forms.asp

This letter is required for any proposed rulemakings filed on or after August 28, 2009.